H.R. 4020, STATE VETERANS' HOMES NURSE RECRUITMENT AND RETENTION ACT OF 2004; H.R. 4231, DEPARTMENT OF VETERANS AFFAIRS NURSE RECRUITMENT AND RETENTION ACT OF 2004; H.R. 3849, MILITARY SEXUAL TRAUMA COUNSELING ACT OF 2004; H.R. 4248, HOMELESS VETERANS ASSISTANCE REAUTHORIZATION ACT OF 2004; AND A DRAFT BILL TO REFORM THE QUALIFICATIONS AND SELECTION REQUIREMENTS FOR THE POSITION OF THE UNDER SECRETARY FOR HEALTH

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

MAY 6, 2004

Printed for the use of the Committee on Veterans' Affairs

Serial No. 108–40

U.S. GOVERNMENT PRINTING OFFICE

99–931PDF WASHINGTON : 2005

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

CHRISTOPHER H. SMITH, New Jersey, *Chairman*

MICHAEL BILIRAKIS, Florida
TERRY EVERETT, Alabama
STEVE BUYER, Indiana
JACK QUINN, New York
CLIFF STEARNS, Florida
JERRY MORAN, Kansas
RICHARD H. BAKER, Louisiana
ROB SIMMONS, Connecticut
HENRY E. BROWN, JR., South Carolina
JEFF MILLER, Florida
JOHN BOOZMAN, Arkansas
JEB BRADLEY, New Hampshire
BOB BEAUPREZ, Colorado
GINNY BROWN-WAITE, Florida
RICK RENZI, Arizona
TIM MURPHY, Pennsylvania
LANE EVANS, Illinois
BOB FILNER, California
LUIS V. GUTIERREZ, Illinois
CORRINE BROWN, Florida
VIC SNYDER, Arkansas
CIRO D. RODRIGUEZ, Texas
MICHAEL H. MICHAUD, Maine
DARLENE HOOLEY, Oregon
SILVESTRE REYES, Texas
TED STRICKLAND, Ohio
SHELLEY BERKLEY, Nevada
TOM UDALL, New Mexico
SUSAN A. DAVIS, California
TIM RYAN, Ohio

PATRICK E. RYAN, *Chief Counsel and Staff Director*

SUBCOMMITTEE ON HEALTH

ROB SIMMONS, Connecticut, *Chairman*

JERRY MORAN, Kansas
RICHARD H. BAKER, Louisiana
JEFF MILLER, Florida
JOHN BOOZMAN, Arkansas
JEB BRADLEY, New Hampshire
BOB BEAUPREZ, Colorado
GINNY BROWN-WAITE, Florida
RICK RENZI, Arizona
CLIFF STEARNS, Florida
TIM MURPHY, Pennsylvania
CIRO D. RODRIGUEZ, Texas
BOB FILNER, California
VIC SNYDER, Arkansas
TED STRICKLAND, Ohio
SHELLEY BERKLEY, Nevada
TIM RYAN, Ohio
LUIS V. GUTIERREZ, Illinois
CORRINE BROWN, Florida
DARLENE HOOLEY, Oregon

CONTENTS

May 6, 2004

H.R. 4020, STATE VETERANS' HOMES NURSE RECRUITMENT AND RETENTION ACT OF 2004; H.R. 4231, DEPARTMENT OF VETERANS AFFAIRS NURSE RECRUITMENT AND RETENTION ACT OF 2004; H.R. 3849, MILITARY SEXUAL TRAUMA COUNSELING ACT OF 2004; H.R. 4248, HOMELESS VETERANS ASSISTANCE REAUTHORIZATION ACT OF 2004; AND A DRAFT BILL TO REFORM THE QUALIFICATIONS AND SELECTION REQUIREMENTS FOR THE POSITION OF THE UNDER SECRETARY FOR HEALTH

THURSDAY, MAY 6, 2004

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 334, Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Miller, Boozman, Brown-Waite, Renzi, Murphy, Rodriguez, Snyder, Strickland, Berkley, and Ryan.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The subcommittee will come to order. I want to welcome my fellow members of the subcommittee, distinguished witnesses, and others in attendance. And I want to offer or extend a special welcome to Gordon Mansfield, the newly confirmed deputy secretary of Veterans Affairs. This is his first appearance before the committee.

[Applause.]

Mr. MANSFIELD. Thank you, Mr. Chairman.

Mr. SIMMONS. He looks great over there, and congratulations. As I think many of us know, he is a highly decorated Vietnam veteran who suffered disabilities, as I recall, during the Tet offensive of 1968. Welcome home, and congratulations.

Mr. MANSFIELD. Thank you, sir.

Mr. SIMMONS. This is a legislative hearing. We have five bills before the subcommittee. They are as follows: H.R. 4020, the State

Veterans' Homes Nurse Recruitment and Retention Act of 2004; H.R. 4231, Department of Veterans Affairs Nurse and Recruitment and Retention Act of 2004; H.R. 3849, Military Sexual Trauma Counseling Act of 2004; H.R. 4248, the Homeless Veterans Assistance Reauthorization Act of 2004; and a draft bill that I am considering introducing based on the testimony we hear today that would reform the qualifications and selection requirements for the currently vacant position of the Under Secretary for Health, an important issue and one in which I will rely on witnesses and my colleagues to come up with some decisions.

Before our first panel, and what I would ask is that the complete statement that I have be inserted for the record. I won't read the full statement. And I will now ask my colleague and friend, Mr. Rodriguez, our distinguished ranking member, if he has any opening comments he would like to make.

[The prepared statement of Chairman Simmons appears on p. 78.]

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman. I want to thank the panelists that are going to be testifying here today, and you for holding this legislative hearing today. I am looking forward to hearing the views of our witnesses and your remarks. I want to just make a few comments.

I am very pleased that we will hear testimony today on H.R. 3849, the Military Sexual Trauma Counseling Act of 2004. I introduced this bill in February to permanently extend the VA's authority to provide counseling and treatment for both women and men who have experienced sexual trauma during their services in the military. Current authority for the program expires at the end of this year.

Congress first authorized military sexual trauma counseling in 1992. Given the overwhelming demand that has been demonstrated for this program, thousands of veterans in addition to Reservists and National Guardsmen that have served, it has been expanded and extended. The time is right to make this program a permanent part of the Veterans Healthcare Administration. Women will continue to comprise an increasing proportion of the military population, at least a fifth of our Armed Services by the end of this decade. I am pleased that we are on the road to ensuring this program will be here for them.

H.R. 4020, State Veterans' Home Nurse Recruitment and Retention for 2004; and H.R. 4231, Department of Veterans Affairs Nurse Recruitment and Retention Act of 2004, are two bills with a goal of helping our veterans' institutions with the looming nursing shortage. We must explore every viable option in assisting these organizations to meet their workforce challenges so our veterans won't be neglected or won't have a negative impact. H.R. 4020 established an education incentive fund to assist state homes and H.R. 4231 uses a variety of approaches, including a pilot to explore contracted recruitment initiatives to put the VA in the forefront of pursuing a high-quality workforce. I am also very supportive of the efforts to provide more flexible work schedules for

our nursing workforce and believe that this will yield considerable benefits for the VA.

I am also very supportive of Chairman Smith's bill to increase the program spending limit for the homeless grant and per diem program for the next 4 years. Although the VA has taken proactive measures to address the needs of homeless veterans, we have a very long way to go in meeting Congress' goal to eliminate chronic homelessness for veterans by 2011.

Mr. Chairman, the last bill we have before us today attempts to reform some of the selection criteria and the processes for which the administration selects the VA Under Secretary for Health. I am appreciative of your agreeing to bring this bill to the hearing as a draft because I believe we need to hear the advice from some of the VA stakeholders. In my view, the proposed bill would affect one of our veterans' greatest opportunities for input into the leadership of the VA. If veteran service organizations are satisfied with this consultative role, rather than actually helping to nominate the candidates for the Under Secretary of Health, I will be pleased to consider this reform.

I urge our witnesses to take this opportunity to comment on all the provisions of this bill. If you choose to defer, once again if you choose to defer, this bill will likely be favorably approved by the subcommittee next week. I will warn or ask each of our veterans' service organizations that when they testify to please comment on that particular piece of legislation because I look forward to hearing from you.

And, Mr. Chairman, again, thank you for holding this hearing today and I appreciate your participation and partnership. And I do want to also openly thank you for coming down to San Antonio. We had a great hearing in San Antonio and people are still talking about that. So you and Mr. Miller got to come back and spend a little more time. It was great to see you down there and get endorsed by three Republicans. So thank you very much. I am not sure how much it helped me back home but I do want to thank you for coming down to San Antonio. And, Congressman Miller, thank you very much for taking the time. I know how difficult it is to leave your own districts and to come down. But I know that at least by going down there you get a feel of what you might need in your own backyard, right? Thank you very much.

Mr. SIMMONS. Well, thank you for those kind comments. For those that weren't aware, we had a subcommittee field hearing in San Antonio within a few blocks of the Alamo. And as we fight for our budget, I think remembering the Alamo is probably a good slogan to have. But I will also say that I actually learned a lot from the visit, in particular in the area of nursing and nurses, nursing retention, and acquiring nurses into the system. And a couple of the bills that we have before us today address just those issues. So it was a very useful visit. And we got a lot out of it. And we appreciate your hosting us down there.

That being said, we have before us today our first panel, representing the Department of Veterans Affairs. In our first panel, the Honorable Gordon Mansfield, again, the deputy secretary of Veterans Affairs, accompanied by the VA general counsel, the Honorable Tim S. McClain—good morning—Dr. Jonathan Perlin, acting

Under Secretary for Health, and Mr. Thomas J. Hogan, acting deputy assistant secretary for human resources and management. Welcome to all.

Mr. Secretary, we appreciate your appearing here today. We look forward to your testimony. And, as you know, we do have written comments which we can review if you want to summarize. There probably will be a light going. And I will defer questions until you have completed your testimony. Thank you.

STATEMENT OF GORDON H. MANSFIELD, DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY TIM S. MCCLAIN, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; JONATHAN B. PERLIN, M.D., ACTING UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; AND THOMAS J. HOGAN, DEPUTY ASSISTANT SECRETARY FOR HUMAN RESOURCES MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS

Mr. MANSFIELD. Thank you, Mr. Chairman, and good morning to you and the members of the committee. I asked that my formal written statement be entered into the record.

I would be pleased to discuss several legislative proposals related to veterans health care. First H.R. 4248, which proposes to extend the VA's authority to carry out the Homeless Providers Grant and Per Diem Program to September 30, 2008 and increases authorizations to $100 million in appropriations for Fiscal Year 2005 through 2008. VA strongly supports H.R. 4248. VA's Homeless Providers Grant and Per Diem Program is a highly successful collaborative effort between the VA, nonprofit organizations, local and state government agencies that furnishes needed outreach, supportive service, and transitional housing services to homeless veterans. The need to develop more transitional housing for homeless veterans continues. We estimate full funding for Fiscal Years 2006, 2007 and 2008 will require respectively $91 million, $82 million, and $86 million. And we welcome the committee's proposal to increase the level of authorized appropriations.

On H.R. 3849, which would permanently authorize the VA's program to provide counseling services and care for veterans who experience sexual trauma while on active duty, currently the VA's authority for this program extends only through December 31, 2004. The number of veterans seeking VA counseling and treatment for military sexual trauma continues to increase at a substantial rate. Therefore VA must continue providing sexual product counseling and related health care to these current and future veterans without any lapse in program authority. The VA strongly supports making this treatment authority permanent.

On H.R. 4020, the VA opposes H.R. 4020, which would require the VA to pay states to assist in hiring and retaining nurses at state veterans homes by using employee incentive scholarship programs or similar programs designed to reduce nursing shortages at state homes. This bill would cost about $8.2 million per year from the medical services appropriations account, thus reducing funds for medical care programs for veterans. The VA now pays states a per diem for the care of each veteran in a state home. These payments are intended to help cover all the costs of operating state

homes, including costs involved in nurse recruitment. In times of fiscal constraint, we do not believe this additional grant to state homes at the expense of VA's own medical programs would be justified.

Before we discuss H.R. 4231 that proposes several initiatives related to nursing recruitment and retention, I want to acknowledge that today is the start of National Nurses Week throughout the United States and tell you that special events are taking place throughout the VA system from now through May 12th to recognize the most important contributions of our nursing professionals. We salute VA nurses who are critical front-line components of the VA health care system.

We understand that the intention of H.R. 4231 is to assist the VA in its ongoing efforts to recruit and retain registered nurses. I am especially pleased the bill includes VA's proposal to enhance flexibility in scheduling tours of duty for registered nurses. This would assist the VA in recruiting and retaining nurses in communities where alternate scheduling of tours is common. Your bill would establish a pilot program to study innovative recruitment tools that address nursing shortages at VA health care facilities. I want to note that the VA is already undertaking numerous initiatives to improve nurse recruitment and retention. Some of the aspects of the bill appear duplicative of those initiatives. Therefore we believe that this proposal is unnecessary and will look forward to further discussions on these issues.

H.R. 4231 will amend Section 7403 of Title XXXVIII to provide that a registered nurse applying for appointment may not be denied appointment because a nurse applicant does not have a baccalaureate degree. I want to emphasize that the lack of a baccalaureate degree is not a bar to appointment under VA's current qualifications standards. Graduations of associate degree programs, diploma programs, and diploma programs with baccalaureate degrees in related fields are eligible for appointment and promotion now. In addition, VHA provides financial support to nurses seeking higher nursing degrees. Because VA does not deny appointment based on the lack of baccalaureate degree, VA believes this proposal is unnecessary.

Finally, Section 5 has a technical amendment to correct the titles of some of the new hybrid occupations and adds additional occupations to those converted. VA supports the clarification of the occupations converted to hybrid status. This section also would convert rehabilitation specialists and blind rehabilitation outpatient specialists to hybrid status. VA is currently reviewing the need for additional hybrid positions and therefore cannot comment on this proposal at this time.

The draft legislation also would amend the procedures for appointment and qualifications of the Under Secretary for Health. This proposal would delete the current statute requirement that the Under Secretary be a physician and substitute in its stead a requirement that the Under Secretary must have executive knowledge, skill, and ability in health care administration, policy formulation, and financial management. Additionally, the draft bill eliminates the current four-year term for that position and current search commission process. Instead, the Secretary would be re-

quired to conduct the search for candidates and to consult with stakeholders similar to those required to be on the search commission prior to recommending a candidate to the President.

The proposal also would allow the President to fill a vacant Under Secretary for Health position in a more expeditious manner without sacrificing important stakeholder input.

VA supports enactment of these amendments as an improvement over current law but we believe the best outcome would be to amend Section 305 to provide simply that the Under Secretary is appointed by the President, by and with the advice and consent of the Senate, and that the Under Secretary shall supervise the Veterans Health Administration under the authority of the Secretary of Veterans Affairs. VHA medical system is the largest in the world with 158 hospitals, 850 ambulatory care and community-based outpatient clinics, 132 nursing homes, 42 domiciliaries, comprehensive home care programs, service networks, and 206 veteran readjustment counseling centers. VA's medical system is the Nation's largest and serves as a back-up to the Department of Defense during national emergencies and as a federal support organization during major disasters. VA also manages the largest medical education and health profession training program in the United States. VA has recently experienced unprecedented growth in the medical system workload. The person who heads the VHA must have significant executive leadership ability and a demonstrated track record.

Mr. Chairman, we understand that the committee will be working with the Senate Veterans' Affairs Committee during VA's proposed legislation to reform VA's physicians and dentists pay authority. VA very much appreciates the committee's interest in this very important subject.

We also request the committee to act on draft bills we forwarded to Congress that would provide comparability pay for the director of nursing programs, for nurse executive pay, and clarify the authority of the Secretary to promulgate regulations relating to Title XXXVIII employees conditions of employment and to clarify the exclusion from coverage under general civil service laws of Title XXXVIII personnel laws and regulations.

Mr. Chairman, that concludes my remarks, and I would be pleased to answer any questions you may have.

[The prepared statement of Mr. Mansfield appears on p. 84.]

Mr. SIMMONS. Mr. Secretary, do any of your colleagues have anything they would like to add to that testimony?

Dr. PERLIN. No, thank you.

Mr. SIMMONS. Very smart. The message is you were thorough and complete, and there is nothing more to be said.

Let me focus my questions on the draft proposal because that may be the one with which people are least familiar. As I understand it, current law requires the Under Secretary for Health to be a doctor of medicine, a physician, a medical doctor. He or she is confirmed to a four-year term. So there is a term limit. It requires the Secretary to appoint a formal search commission chaired by the deputy secretary and consistent of a specified number of members of various organizations. They recommend no fewer than three candidates. The candidates can be sent to the White House without Secretary endorsement or approval. The President can either

choose from the list or return the list. And eventually a nominee appears out of this process which can take up to 18 months. And yet the system that this person would oversee, as you have described, is a very large, a very complex system, a very costly system to operate.

And the idea that the process for replacement could take up to 18 months in a four-year term troubles me and concerns me. And the thing that also concerns me is whether in this day and age the best person to manage this very complex system is a medical doctor as opposed to let's say a chief executive officer in a large health care organization of one form or another. It is my understanding that if you look at some of the major medical companies in the United States, only a handful of CEOs continue to be medical doctors. The others are professional managers, people with executive management skills. So that is the system that we are dealing with. That is the thing that we are looking at.

Let me start, first and foremost, by saying what would be the pros and cons of not requiring this individual to be a medical doctor? And I guess some of my colleagues might have some thoughts on that, as well. Is that a requirement or a mandate that we should continue?

Mr. MANSFIELD. Sir, the first answer is that as you mentioned, we are in an evolving situation, and we are a part of the total health care system in the United States. And when you look, as you mentioned, outside the VA or outside the government, you see changes where these institutions and organizations don't necessarily require that there be a medical doctor in charge, and that has evolved over time. I think what we are saying is that it could still possibly be a medical doctor but we ought to have the ability to look out across this country and try and find the best possible person to manage the largest system, a changing and evolving system, to be able to provide the best health care possible.

Mr. SIMMONS. I appreciate that response. Then the second question goes to the issue of a panel that is required to come up with a list of three individuals. I know there are many different formulations for search committees. Perhaps there is some concern if there is not a panel established, if there is consultation, maybe the consultation will not really take place. Do you have any thoughts on that subject?

Mr. MANSFIELD. Well, as mentioned, part of the purpose here is to get somebody qualified, the highest-qualified person, in place as soon as possible. We have to understand that this is just the start of the system, because when you go through our process, then it has to move on to White House personnel and they have to go through their process and then it moves on to the Senate and then they have to go their process. And then at the end of that, when you finally have a vote on the Senate floor, you get somebody approved. So what we are looking at is an effort to bring that process down where you can get again the best qualified person in place as soon as possible.

I think you have to understand that from my boss' perspective, the Secretary of Veterans Affairs, and the administration perspective, there is no way that we are going to go forward without some consultation with the veteran service organizations, with the med-

ical education component of this country, with the Department of Defense, which we partner with in many procedures that we go forward on, and that would still be carried out. It just wouldn't be done formally and it wouldn't require the extensive time and administrative backup that we have to go through, we are in the middle of that right now, the administrative process that we go through to reach the same end. So there still would be consultation with the stakeholders and they still would have a say in how we go forward and they still would be involved.

Mr. SIMMONS. For the four-year term, my assumption is the four-year term was designed to reflect the presidential term, giving each President the right or the opportunity to choose their own person, and yet, as we on this committee know, there is no Republican, there is no Democrat when it comes to veterans. It is kind of politically neutral, at least we hope it is. Should we lift that burden, should we have it open-ended, allow each President to choose his own successor but also keep it open-ended so that that does not occur or should we stick with the mandated four-year term?

Mr. MANSFIELD. Sir, we think if you look at the history and see what has happened, we had a situation where the four-year term has not measured up with the President's term. There has been overlaps and changes and back and forths so that is really not the issue. The real issue, as you mentioned, is do you need a Democrat or a Republican in this job and the answer is you don't. What you need is a good person in charge of health care and that should be done no matter what Administration is in charge and you should make a choice based on the qualifications and the person that you are going to get to work for you.

Mr. SIMMONS. Thank you.

Mr. Rodriguez?

Mr. RODRIGUEZ. Thank you very much. Congratulations, and thank you for being here with us. Let me ask you on the homeless programs I know that we have been looking at the recommendations to authorize additional resources in that area. Last year the VA spent about $70 million of the $75 million that was authorized for the program but the previous year, in 2003, it only spent $43 million. I am wondering, because I know we are looking at increasing that amount, trying to get some assurance because the previous year we only spent about half of that, the $43 million out of the $75.

Mr. MANSFIELD. Sir, part of it is a question of emphasis and priority. And I would tell you that with this Secretary that I work for and myself that that is a priority. A good example is that I just visited Hampton VA Medical Center yesterday and in the process of going through that institution visited with a homeless veteran program that is contracted out through this initiative to the Salvation Army. We have to provide the initiative and the priority from the top and we are doing that and that will make sure that we carry through on the expenditures, I believe.

Mr. RODRIGUEZ. Let me ask you, I know you mentioned you are concerned with H.R. 4020 concerning nursing. What is the shortage of nursing within the VA system? And, if you are not in favor of this, what kind of incentives or programs do you think we might need in order to expand in that area?

Mr. MANSFIELD. There are two issues that we have to pay attention to in this area. Number one is that there is a nurses study commission that the VA put in place that is getting ready to bring its full report to bear and that is going to come up with some important initiatives that the VA will back and we will be more than happy to discuss with you and attempt to move forward. So that is one issue going forward.

The other issue that in the context of the qualifications I went and checked on that and although we understand from studies that have been done that with a four-year RN you get better outcome results and we are trying to get the possible for the veterans we are treating. Also, we have been able to utilize the system to have folks at all different levels of the education component come in and be a part of the system and we also have education training programs to assist them to move forward to get advanced degrees. So I think we are doing what we can in that area and it is not a bar to hiring folks.

One of the important things I learned from the nursing commission's draft report was for example there are 11,000 people who want to go to nursing school in this country that can't get a slot because there isn't room there every year. VA should be doing something, we should be working with you to devise programs that allow us to move into areas like that and go forward and get additional nurses on board. And if you want more detail, I would defer to the medical side of the house, which is you.

Mr. RODRIGUEZ. Go ahead.

Dr. PERLIN. Thank you. I endorse heartily Secretary Mansfield's comments that VA has an opportunity to contribute to the nursing education. We in fact have 58,000 nurses currently, 38,000 are at baccalaureate or above. But we welcome all nurses. In fact, we couldn't perform our mission of service to veterans without all sorts of nurses. We have in fact educated over 3,000 nurses from associate degree level to baccalaureate or above through our National Nursing Education Initiative, and we are very proud of that program.

Mr. RODRIGUEZ. Okay, what is, once again, the nursing shortage that we find ourselves in?

Mr. MANSFIELD. Across the system.

Mr. RODRIGUEZ. Throughout the system.

Dr. PERLIN. Right.

Mr. MANSFIELD. Do you have that?

Dr. PERLIN. Yes, the vacancy rate is 9.5 percent, is that right, Tom?

Mr. HOGAN. Nine percent.

Dr. PERLIN. Nine percent currently is the——

Mr. RODRIGUEZ. Nine percent? So then that is what, about 5,000 that we need, 5,400? Something like that?

Mr. HOGAN. Yes, sir, it would be something in excess of about 4,500, and last year we hired about 4,100 nurses. So 40 percent were AD-prepared. The remainder would be BSN prepared or higher.

Mr. RODRIGUEZ. But right now we have less than 5,000 vacancies for nurses throughout the system. Let me ask. Do you have any thoughts on Dr. Mengel's recommendations to use the National

Nurse Education Initiative funds to nurture nurses' interest in obtaining the academic credentials to become nurses for the faculty?

Dr. PERLIN. We would support that.

Mr. RODRIGUEZ. Okay, supportive of that. Thank you. Thank you very much.

Mr. SIMMONS. Mr. Murphy?

Mr. MURPHY. Thank you, Mr. Chairman. Just a couple of quick questions. When we talk about the nursing shortage, how much do you spend on nurse training? Do you have a sense of cost per employee or overall, in aggregate, for our training and recruitment for nurses as they enter the system, any sense of that?

Mr. MANSFIELD. Do you have that?

Dr. PERLIN. Sorry, I don't have that number. I can get that for the record.

Mr. MURPHY. That would be important in the record, because when we talk about the amount of money that this scholarship program may cost, it would be important to know if there is an offset by keeping people compared to what it would cost to recruit and train once they come into the system. I also should disclose that I have a sister-in-law in the VA system who is a nurse, so I don't want to seem like I am just trying to help her kids out.

Mr. SIMMONS. We should say congratulations.

Mr. MURPHY. She will probably send you a thank you card. Also, I wonder, you talked about the 9 percent opening, does the VA hire part-time positions, replacements, or extend other people's work into overtime when trying to make sure any gaps are filled? Do we have a number for what that might cost for hiring part time or replacement or overtime workers?

Dr. PERLIN. That is a number we would have to develop. It is a substantial number when we contract for temporary or contract nursing to supplant when we don't have it filled. One number in response to your previous question that may be of interest concerns nursing scholarships for education to retain nurses in the system. We spend over $35 million on the program to advance nurses educational levels.

Mr. MURPHY. That is for the nurses themselves to advance?

Dr. PERLIN. That is correct, on individuals who aspire to nursing from other careers.

Mr. MURPHY. And part of that is part of your motivation to keep them in the system by providing those benefits to them?

Dr. PERLIN. Yes, sir.

Mr. MURPHY. Okay. And thirdly, I wanted to know about this 9 percent number you talked about in terms of shortage. I am sure that is spread out over a wide range of specialities but whenever there is a shortage in hospitals, it raises questions of what impact that has upon medical care. Does it cause delays in scheduling? Does it cause delays, put people in the waiting room to get their appointments? Does it cause any kind of compromise of services, cancellations, longer waiting times? Can you give me some sense of what impact that does have on health care delivery?

Dr. PERLIN. Congressman, you are absolutely right. When there is a shortage of nurses, it impacts our ability to serve veterans as effectively as we might. In addition to the variation by specialty, the variation that also is of concern is that geographically it is mal-

distributed. In certain areas, there may be really a higher level of vacancy because of non-competitive salaries, by virtue of limited flexibility relative to private sector, or competitors for the limited number of nurses in the market.

So it really varies across the country from state to state, city to city.

Mr. MURPHY. Does the private sector tend to pay more for nurses than VA?

Dr. PERLIN. I am sorry?

Mr. MURPHY. Does the private sector tend to pay more for nurses than the VA?

Dr. PERLIN. Yes, they do. And there are some extraordinary marketing tools that are used in the contemporary nursing recruitment environment from signing bonuses to even in their local market some of us may have heard advertisements where one particular facility is paying for weekly house cleaning. Recruitment bonuses, they take the forms of relocation assistance and also the flexibility of tours. One of the concerns that is not necessarily directly financial is the inability to control one's schedule and to exert a little more ability to either compress the number of work days, particularly for a younger individual who is balancing that with family responsibilities.

Mr. MURPHY. And that is one of those things I am aware of where there are nursing shortages. For example in the Pittsburgh area, advertisements go out to nurses offering them bonuses to go from one job to another. In many cases, they find it is more economically fruitful for them to simply sign on with a temp agency and go from place to place. And although these are highly qualified nurses and they have every right to do that, it seems to me there is also a certain amount of stability in the system if you know that some nurses are working for you day to day.

Dr. PERLIN. Yes, sir, you are absolutely correct. The other thing that provides stability is their relationship with the educational institutions providing familiarity and ultimately an affinity to working for veterans and serving veterans. There is also an attraction to the electronic support, such as bar code medication administration that make it not only a safer environment for our patients but also safer for the practitioners, including nurses.

Mr. MURPHY. Well, Mr. Chairman, I would just appreciate if one of the things they could follow up with are those items in terms of giving us a sense of what it does cost to hire temp employees over time and how that would be offset by some of these other cost savings and any statements with regard to what you see happening, if this does have an impact upon delaying some of the services at times because there was a shortage. And thank you very much for your testimony.

Mr. MANSFIELD. We will do that.

Mr. SIMMONS. Thank you. Mr. Snyder. And staff will follow up on those questions. Excuse me, Mr. Murphy. Mr. Snyder?

Dr. SNYDER. Thank you, Mr. Chairman. Secretary Mansfield, I wanted to ask you about Mr. Simmons' draft bill here on the Under Secretary for Health. As I understood both your written statement and your testimony today, you want to see this change to get more flexibility but your suggestion is that we essentially just have a one

or two sentence provision that just says, "The Under Secretary for Health shall be appointed by the President with the advice and consent of the Senate." Because of the kinds of things that Mr. Simmons includes in here in terms of the consultative process, any reasonable person assume a lot of that would go on any way, is that your perspective?

Mr. MANSFIELD. That is the point I was trying to make, sir, that there is no doubt that the stakeholders, the veteran service organizations that represent the patients, the medical schools and the education schools that represent the folks that we work with, the associations, for example, the American Nursing Association, or employee associations would be involved as they ordinarily are in the process, either formally or informally. We are just making it a little bit more informal to try and get to the result quicker.

Dr. SNYDER. My guess is that some of those groups perhaps wouldn't be involved in the process, that they would be involved in the process either before the appointment or after the appointment. If they weren't consulted, the President's people would hear about it after the process, which I guess can work both ways.

Mr. MANSFIELD. Usually they want to know that you have done your job before you make the decision.

Dr. SNYDER. Yes, I understand. But my characterization is correct, your preference would be let's just do it as a one line thing and leave out any kind of process here assuming that a lot of that will occur, is that a fair statement?

Mr. MANSFIELD. That is the position, yes, sir.

Dr. SNYDER. Yes, I don't think that is unreasonable. And I think Mr. Simmons' draft is trying to move in the direction that you want.

I did notice one thing, Mr. Chairman, on your draft, which it talks about "The Secretary shall recommend an individual," but that makes the assumption that we have a Secretary. And when we are first starting an administration, it may very well be that, I don't see any reason you couldn't have the process going along, the President may reach a conclusion quicker about the Under Secretary of health or it would be vetted quicker than they would for the Secretary of Veterans Affairs; so that may be something to look at.

My feeling, I understand I think probably why this was set up originally that it be an M.D. requirement, but I don't know what Dr. Murphy's feelings are but I think that there are a lot of physicians that are interested in management, in public policy issues, and others that are just interested in practicing medicine. I don't think there is anything magic about having an M.D. for this position or not having an M.D. for the position. The key is to have somebody that can do the job. I think that is all.

Mr. Chairman, it may be that we want to move in the direction of a really simple kind of draft here, I mean a language change here. And if at some point it seems to be abused by a subsequent President, I am sure that the Congress would be glad to——

Mr. SIMMONS. Will the gentleman yield?

Dr. SNYDER. Sure.

Mr. SIMMONS. I appreciate his comments very much because he is a physician. I have a CRS report that requested listing medical

degrees held by chief executive officers and presidents of various companies in the health care industry. And it lists three in about 35 or 40 major corporations and I will ask that this be inserted in the record. Our purpose in looking at that provision was not to degrade the role of physicians. I have physicians in my family. I think we all value their expertise and their skill. But simply to consider whether that criteria should be opened up for others who may have management skills which under certain circumstances may be of equal or greater value. I am interested to see that the VA is looking for even more simple process than we had envisioned. And I will certainly take that testimony to heart.

[The provided material follows:]

Congressional Research Service

TEL: (202) 707-5700 FAX: (202) 707-6745

Transmittal April 30, 2004

TO: **House Committee on Veterans' Affairs**
Subcommittee on Health

ATTN: Kathleen S. Greve

FROM: Jim Riehl
Information Research Division
TEL: (202) 707-8988 FAX: (202) 707-3662

SUBJECT: Your request for information on **medical degrees held by Chief Executive Officers and Presidents of various companies in the health care industry**

Enclosed is a series of tables listing "top" companies in the following health care industry sectors; health insurance, nursing home chains, assisted living chains, home care chains, pharmaceutical companies, publicly-held managed healthcare providers, and medical equipment and supply companies. Except for the listing of health insurance companies (obtained from *National Underwriter Life & Health*), all rankings were obtained from the Standard & Poor's *Industry Surveys* publications cited in each table. 62 companies are listed.

Several CRS staff reviewed company websites, database resources, biographical resources, and other appropriate sources (including contacting the companies in some cases) to identify the educational background of the Chief Executive Officer (CEO) and President of each company. Since corporate structures and executive titles can vary, we only listed a President where it was evident that the position of President was for the company in the tables, not for a division, branch, subsidiary, etc. of the company. In some cases, the company listed is a subsidiary of another company and the CEO and President of the parent company may be listed.

The enclosed material is forwarded in response to your request. Please review the contents and do not hesitate to call if I can be of further assistance.

Information Research Division

U.S. Top 10 Health Insurance Companies by Value of Group Health Premiums in Dollars for 2002 (National Underwriter Life & Health, August 18, 2003)		
Company	**CEO/President**	**Medical Degree**
United Healthcare Insurance Co. (subsidiary of United Health Group)	William W. McGuire, M.D. (CEO of parent) Ronald B. Colby (President)	Yes None Identified
Connecticut General Life Insurance (subsidiary of CIGNA)	Edward Hanway (CEO and President of CIGNA)	None Identified
Health Care Service Corp.	Raymond F. McCaskey (CEO) Gail Bodreaux (President)	None Identified None Identified
Guardian Life Insurance Co. of America	Dennis J. Manning (CEO and President)	None Identified
Aetna Life Insurance Co.	John Wallis Rowe, M.D. (CEO and President)	Yes
National Heritage Insurance Co. (Subsidiary of EDS)	Matthew Chambers (President) Michael J. Jordan (CEO of EDS) Jeffrey M. Heller (President of EDS)	None Identified None Identified None Identified
Metropolitan Life Insurance Co.	Robert H. Benmosche (CEO and President)	None Identified
Humana Insurance Co.	Michael McCallister (CEO and President)	None Identified
Blue Cross & Blue Shield of Florida	Robert Lufrano, M.D. (CEO and President)	Yes
Principal Life Insurance Co.	J. Barry Griswell (CEO and President)	None Identified

Largest Investor-Owned Hospital Chains – 2002 (Standard & Poor's Industry Surveys, Healthcare Facilities, March 25, 2004)		
Company	**CEO/President**	**Medical Degree**
HCA	Jack O. Bovender (CEO) Richard M Bracken (President)	None Identified None Identified
Tenet Healthcare	Trevor Fetter (CEO and President)	None Identified
Triad Hospitals	James D. Shelton (CEO) No President Listed	None Identified
Universal Health Service	Alan B. Miller (CEO and President)	None Identified
Health Management Associates	Joseph V. Vumbacco (CEO and President)	None Identified

Top 10 Nursing Home Chains – 2002 (Standard & Poor's Industry Surveys, Healthcare Facilities, March 25, 2004)		
Company	**CEO/President**	**Medical Degree**
Beverly Enterprises	William R. Floyd (Chairman of the Board, President, and CEO)	None Identified
ManorCare	Paul A. Ormond (Chairman, President, and CEO)	None Identified
Mariner Health Care	C. Christian Winkle (President, CEO, and Director)	None Identified

Kindred Healthcare	Edward Kurt (CEO, Chairman, and President)	None Identified
Life Care Centers of America	Forrest L. Preston (Chairman and owner of the firm) Don J. Gardina (President)	None Identified None Identified
Sun Healthcare Group	Richard K. Matros (Chairman, CEO)	None Identified
Integrated Health Services	Tony Misitano (CEO and President)	None Identified
Genesis Health Ventures	George V. Hager, Jr. (CEO and Chairman)	None Identified
Extendicare Health Services	Mel Rhinelander (CEO and President)	None Identified
Evangelical Lutheran Good Samaritan Society (not for profit)	David J. Horazdovsky (CEO and President)	None Identified

Top 5 Assisted Living Chains – 2002 **(Standard & Poor's Industry Surveys, Healthcare Facilities, March 25, 2004)**		
Company	**CEO/President**	**Medical Degree**
Emeritus Corp.	Daniel Baty (CEO and President)	None Identified
Alterra Healthcare Corp.	Mark Ohlendorf (CEO) No President Listed	None Identified
Sunrise Senior Living	Paul J. Klaasen (Founder, CEO) Thomas B. Newell (President)	None Identified None Identified
Marriott Senior Living Services (Purchased by Sunrise Senior Living)		

Brookdale Assisted Living (subsidiary of Brookdale Living Communities, Inc.)	Mark J. Schulte (CEO and Chairman) John P. Rijos (President)	None Identified None Identified

Top 7 Home Care Chains – 2002
(Standard & Poor's Industry Surveys, Healthcare Facilities, March 25, 2004)

Company	CEO/President	Medical Degree
Interim Healthcare	Allan Sorensen (CEO and President)	None Identified
Gentiva Health Services	Ron Malone (CEO) Al Perry (President)	None Identified None Identified
Maxim Healthcare Services	Bryan Wynne (President)	None Identified
OPTION Care	Rajat Rai (CEO) Richard M Smith (President)	None Identified None Identified
Kelly Home Care Services (subsidiary of Kelly Services)	Terence Adderley (CEO) Carl T. Camden (President) Gil Rosales (Director of Kelly Home Care)	None Identified None Identified None Identified
Medshares, Inc.	Glen Cavallo (President)	None Identified
Coram Healthcare	No current President or CEO according to switchboard	None Identified

Leading Pharmaceutical Companies – 2002 (Standard & Poor's Industry Surveys, Healthcare: Pharmaceuticals, December 11, 2003)		
Company	**CEO/President**	**Medical Degree**
Pfizer	Hank McKinnell, Ph.D. (CEO and Chairman) No President listed	None Identified
GlaxoSmithKline	Dr Jean-Pierre Garnier (Executive Director and CEO) No President listed	PhD in pharmacology and an MS in pharmaceutical science from the University of Louis Pasteur in France
Merck	Raymond V. Gilmartin (Chairman, President, and CEO)	None Identified
AstraZeneca	David R. Brennan (President and CEO)	None Identified
Aventis (A two-tier governance structure. Aventis is organized as a French stock corporation (société anonyme) with a Management Board (Directoire) and a Supervisory Board (Conseil de Surveillance). The Management Board acts in the name of the company and is responsible for managing the business of Aventis, particularly in deciding general policy matters and determining the overall business and financial strategy of the company. The Supervisory Board is responsible for appointing the Management Board, including its chairman and vice chairman, and for overseeing the management of the Aventis businesses by the Management Board.) [from the company's website]	Igor Landau (Chairman of the Management Board of Aventis) Richard J. Markham (Vice Chairman of the Management Board and Chief Operating Officer)	None Identified Graduated from Purdue University School of Pharmacy

Johnson & Johnson	William C. Weldon (Chairman of the Board, CEO, and Chairman of the Executive Committee) James T. Lenehan (President) [resigned effective February 1, 2004 – retirement on June 30, 2004]	None Identified
Novartis	Daniel Vasella, MD (Chairman and CEO) No President Listed	Graduated from the University of Berne with a medical degree
Bristol-Myers-Squibb	Peter R. Dolan (Chairman and CEO) No President Listed	None Identified
Pharmacia Company was acquired by Pfizer in 2003.		
Wyeth	Robert Essner, Chairman, President, and CEO	None Identified

7 Largest Publicly-Held Managed Healthcare Providers (Ranked by Enrollment as of June 30, 2003) (Standard & Poor's Industry Surveys, Healthcare: Managed Care, September 25, 2003)		
Company	**CEO/President**	**Medical Degree**
UnitedHealth Group	William W. McGuire, M.D. (Chairman and CEO)	M.D. with highest honors, University of Texas Medical Branch, 1974. Board-certified in internal and pulmonary medicine.
	Stephen J. Hemsley, President and Chief Operating Officer	None Identified
Aetna, Inc.	John W. Rowe, M.D. (Chairman and CEO)	Dr. Rowe received his medical degree from the University of Rochester School of Medicine in Rochester in 1970. He did his residency in internal medicine at Beth Israel Hospital in Boston and served as a clinical and research fellow at Massachusetts General Hospital and Harvard Medical School, as well as the National Institutes of Health.
	Ronald A. Williams (President)	None Identified
WellPoint Health Networks (WellPoint is merging with Anthem in 2004)	Leonard D. Schaeffer (Chairman & CEO) No President listed	None Identified

CIGNA	H. Edward Hanway (Chairman and CEO) Terry L. Kendall (President, CIGNA International) Gregory H. Wolf (President, CIGNA Group Insurance)	None Identified None Identified None Identified
Anthem Inc. (WellPoint is merging with Anthem in 2004)	Larry C. Glasscock (Chairman of the Board, President, and CEO)	None Identified
Humana	Mike McCallister (President and CEO)	None Identified
Health Net	Jay M. Gellert (President and CEO)	None Identified

Select Medical Equipment & Supply Companies – 2003 **(Standard & Poor's Industry Surveys, Healthcare: Products & Supplies, March 18, 2004)**		
Company	**CEO/President**	**Medical Degree**
Bard (C.R.)	Timothy M. Ring (CEO) John H. Weiland (President)	None Identified None Identified
Bausch & Lomb	Ronald L. Zarrella (CEO) No President Listed	None Identified
Boston Scientific	James Tobin (President & CEO)	None Identified
Guidant Corp.	Ronald W. Dollens (President & CEO)	None Identified
Medtronic	Arthur D. Collins (CEO) No President Listed	None Identified

CRS-10

St. Jude Medical	Terry L. Sheperd (CEO) Daniel J. Starks (President)	None Identified None Identified
Stryker	John W. Brown (CEO) Stephen P. MacMillan (President)	None Identified None Identified
Zimmer	J. Raymond Elliott (President & CEO)	None Identified

Dr. SNYDER. Yes, if I may make one final comment. I understand what you said the CEOs in the company. Of course, going back I guess to my practicing medicine days, a lot of us in practice had multiple occasions I think in dealing with large insurance companies when we wished they had M.D.'s making decisions. And so that may not be your strongest point there, Mr. Simmons. But I appreciate it, thank you.

Mr. SIMMONS. Point well-taken.

Next, Mr. Renzi?

Mr. RENZI. Thank you, Mr. Chairman. It is good to see you, Secretary Mansfield. Thank you for your testimony. I appreciate being with you.

Mr. MANSFIELD. Thank you.

Mr. RENZI. I wanted to share just a couple of stories with you and maybe engage you a little bit in conversation. I had a chance to go out to Coconino Community College in Flagstaff, AZ, and I walked through and reviewed the first graduating class of nurses in the community college and found the scores, the test scores for this year, the two-year program and then a one-year field program, a three-year total program for the associate degree, and I think they are graduating about 26 nurses that are first class into the community. We have got the Navajo Nation up there, which you have been kind enough to look at, and a lot of need, a lot of real need.

Their test scores, interestingly, are higher than the four-year college, Northern Arizona University, right down the street. And one of the interesting aspects of why was that the concentration for the curriculum was very much on real world practice rather than a theory-based practice that they feel maybe the four-year college is giving.

So I am interested in understanding a little bit about the report you cited where the four-year degree produces better quality or produces, I don't want to put words in your mouth, because I think if that is the mind set that we believe that the four-year program does produce better, then actually there may be some sort of impediment to hiring. There may be a glass ceiling. I am not saying there is. I am just wondering if while you say technically and legally there is no impediment to hiring, if that is the mind set that there is a better quality individual who has a four-year degree and yet, based on the results that I saw, is there a glass ceiling, is there an impediment?

Mr. MANSFIELD. I think what you have is what has happened in the nursing service over a period of time is that they have looked at this and they have made a decision to go through the effort to recruit and hire a nurse and retain that nurse and hopefully have that nurse with us over a total career where they would progress and be promoted and then hopefully reach nurse executive position, that they believe that starting out at that level, aiming for that level is the best possible choice.

Since that program has been put in place, there has also, as I mentioned, been the study, and I will refer to Dr. Perlman to give you the details, but my understanding is that shows that with four-year nurses you get better outcomes at the end, which means overall, and again we are talking about totalities here, not individual

cases, that you have better outcomes when you have four-year nurses involved.

The other point I would make, too, though, is, and Dr. Perlin referred to that, is that we are hiring nurses at all levels. And I made the point of discussion leading up to this testimony with Dr. Perlman and the nursing executive that in a situation where the veteran who is a patient has a choice of whether there is a four-year nurse or no nurse or a two-year nurse, I think you can understand that we would as a patient would want to have a two-year nurse. And if you can't fill the positions, then we would go ahead and do it. The other part of it is we have a number of education programs that are available that would help move this person, if they come in with a lower degree, along a career path that would put them in a position to be able to reach the highest levels of nursing, if they want that, in our system, and we really need to work hard to try and retain these.

Mr. RENZI. I am with you, I just want you to take note of the test scores and the graduating class of Coconino.

Dr. Perlin?

Dr. PERLIN. Congressman, we couldn't do our job were it not for the combination of both the baccalaureate and the associate degree nurses. We really welcome both, all, into our environment, particularly with the nursing shortage. In fact, we do like to be able to support the associate degree advancement. But as Secretary Mansfield mentioned, some of the more technical environments really do show better outcomes with the higher levels of training. We would be pleased to submit for the record an article from JAMA, the Journal of the American Medical Association, September 24, 2003, by a nurse, Linda Aiken, that shows in hospitals with higher proportions of baccalaureate, the surgical outcomes were higher.

Now obviously, these were intensive environments and you see an association there but again, we welcome—not only do we welcome, we couldn't do our job—we have 58,000 nurses of all stripes that are in our environment; 40 percent are not baccalaureate-trained. Of those, about 10,000 are associate degree with LVNs or LPNs, licensed practical nurses. And another approximately 9,600 are nursing assistants.

I do need to, if I might, just correct, I mis-spoke on the number, Congressman Murphy, our vacancy rate is 7.1 percent, with a turnover at 9.6.

Mr. RENZI. Okay, thank you. Congressman Murphy, I will need your time back.

Switching gears real quick, on Veterans Day I had a chance to go see a concert on Vet Aid, a Vet Aid concert for the homeless, and this was a nonprofit group, Mr. Secretary, who put together this concert; Motown Music had people from all over Prescott, AZ show up, pay a little money. That organization just went out of business last month when I went back to see how they were doing. How are we doing on making sure we spend down our allocation as it relates to the NGOs, the nonprofit organizations? I think we have got about $750,000 a year, I think, Mr. Chairman, that we are supposed to be allocating to nonprofits.

Mr. MANSFIELD. Sir, I would ask the director of homeless programs, Pete Dougherty, to come forward, if I may, Mr. Chairman, and he can give you the figures exactly.

Mr. RENZI. Absolutely. That is my last question. Thank you, Mr. Secretary.

Mr. DOUGHERTY. Mr. Renzi, I am Pete Dougherty. VA is clearly on target this year, in this fiscal year to spend the available funding that we have for homeless programs. I don't think we will have anything left. We were talking this morning that we will spend virtually every nickel we have available. We get good quality service from nonprofit groups and organizations like the folks you were mentioning.

Mr. SIMMONS. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Chairman, I would like to pass on to you and the others I have got a second committee meeting so I will have to leave before this hearing is complete, but I just wanted to let you know I am doing that because I have other responsibilities.

Mr. SIMMONS. We appreciate that, and I think our witnesses know that many of the members have conflicting assignments.

Mr. STRICKLAND. In regard to the selection process for the Under Secretary of health, I believe that there are huge numbers of people who can satisfy the technical, educational and skill level to do such a job. But in my judgment, especially when it comes to this particular position within the Department of Veterans Affairs, what we need to find is a person with the right attitude and the right philosophy. And having said that then, I am wondering if what is being proposed of having the effect of perhaps diminishing the influence of the various VSOs to have an appropriate input into the selection of such an individual? Could you speak to that? Do you think in any way that this change will diminish the ability of the VSOs to exercise their prerogatives when it comes to whoever is selected to this position?

Mr. MANSFIELD. Sir, I would commit to you that any process that I am involved in, and I know that the Secretary is involved in, that that would not be diminished. Currently the commission that is going forward I think has 11 members and two of those members are representatives of VSOs. I think that in the total process, formal and informal, you could expect that we are probably going to get information from more than just those two that are formally involved in the process. And I think that informal process probably would work in anything you do to change it.

The other thing to keep in mind here, too, is that at the end of whatever we do and at the end of whatever the White House does, you wind up with a name at a Senate hearing where everybody gets an opportunity to come forward and make their position known. And then should that person get out of committee when it goes to the floor, you have another opportunity for the Senate to do its constitutional duty in advising and consent and each and every stakeholder would also have the opportunity to continue to be involved there.

Mr. STRICKLAND. I am amazed, and I don't say this to be critical of anyone, maybe us, but to talk about an 18- month process just seems ludicrous. If it is an 18-month process, why don't we decide

how to do that more quickly? We plan, execute, complete wars in less time than that. And it just seems strange that we accept those kinds of comments here in Washington, DC without saying why not just change that process so it is not 18 months, but maybe I am just blissfully naive about the process.

Mr. MANSFIELD. Well, sir, I have been through three nomination processes where my name has been submitted to the Senate and they have taken 18 months, but some of them have taken longer than others and it is quite an involved process. When this administration—there was a study done, again, to look at that process and it continues to evolve over time and take more and more time as we go forward. So it is a part of the reality that we are dealing with.

Mr. STRICKLAND. So I guess I am blissfully naive. I will move on, but I would just like to say that I hope we do nothing that in any way diminishes the influence of the VSOs over this decision-making process for this reason, I do think that those of us on this committee, the President, the Senate, whoever is involved in this process obviously are concerned about veterans but I do believe that the most objective individuals and organizations in this whole process when it comes to veterans' care are the various veteran service organizations. And I would just hope that we do nothing that would in any way diminish their influence to have input who is selected for this very vital position because, as I said, I think there are probably scores and scores of people who might meet technical requirements but if the attitude toward what the VA needs to be doing and should be doing that I think is so important in this particular position above all others.

Mr. MANSFIELD. Well, I would agree with you, sir, and I would commit that we would go forward on that basis.

Mr. STRICKLAND. Thank you, Mr. Chairman. I think my time is just about up. But I want to thank each of you for being here. Thank you.

Mr. SIMMONS. Thank you. Ms. Brown-Waite?

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman. I agree with Mr. Strickland that we need to do everything possible to ensure that the VSOs are involved and certainly participating in a committee, a process, is appropriate, but I would hope that should that bill pass that whoever would be the person nominated for that position will work very closely with the VSOs before it gets to committee stage.

Going back to H.R. 4231, I want to make sure that the VA isn't going to be shooting itself in the foot on the nurse's issue. At a time when there is a nursing shortage out there, we have to remember that all states license nurses and I heard what Mr. Renzi said and I can tell you that I have been involved in health care policy for about 22 years and it was a phenomenon in New York, it is a phenomenon in Florida, that the higher test scores on the registered nurse exam come from the two-year programs.

And there is one other thing that you all need to take into consideration. I don't want you to deny employment or put any sort of an artificial ceiling there. And I appreciate the fact that there are education programs so that the nurse can go on and get his or her baccalaureate degree. But you have to remember that the com-

munity college, the two-year program, is a far less threatening program for perhaps the 30 or 40-year-old woman to go into for a career change, or perhaps she finds herself in a displaced homemaker situation, where the community college is far less threatening than going to a big university.

And we need to be grateful for the nursing programs in the community colleges, in the two-year schools, because they are producing quality nurses that not only work for the VA but every single health care field out there.

And let me share with you some information that a hospital gave me. They offer what are called preceptorships to nurses coming out of whether it is a two-year program or a four-year program. And they actually have told me that they prefer the nurses from the two-year program to go into the preceptorship, that they are more flexible, they actually are very patient-friendly.

Now I am not putting down four-year baccalaureate nursing degrees in any way, shape, or form, but I want to make sure that you all aren't, either, and that you are not discriminating against—and I think that is the purpose for the language in the bill 4231. It just seems to me, particularly with the nursing shortage that is out there, we need to do everything possible, actually open up more slots through community colleges so that we can have more nurses trained, recruited, and groomed to work with patients.

Mr. Mansfield, Secretary Mansfield, I'd appreciate your comments.

Mr. MANSFIELD. Well, I think Dr. Perlin indicated earlier, and I would agree with him, that we do feel that way. We need nurses across the spectrum to be able to do the job. And I can tell you your comments about the displaced homemaker or other folks, I was just down at Hampton VA Medical Center in the peninsula of Virginia yesterday and the day before, visiting some of our folks and talking to the nurses, and a lot of the recruitment there is in that area and they are bringing those types of folks in. And I had a chance to meet and talk to them.

So we have nurses across the whole spectrum and they are getting the job done, and I think we do understand that we are looking at a shortage and we do understand that we have to be flexible and we do understand that we have to look at the total picture. And I think we are doing that. And I would commit to you that we would continue to make sure that we don't impose any of those ceilings that you are talking about and that we allow the opportunity for each and every person that we recruit to stay with us and complete a career to the best of their capabilities.

Mr. SIMMONS. Ms. Berkley.

Ms. BERKLEY. Thank you very much and welcome. It is very nice to see all of you.

I would be opposed to any change in the law that would make the Under Secretary of health anything but a doctor of medicine. My husband is a nephrologist. He is also a Heritage Foundation Republican. Let me share with you an anecdote of how his practice is and what it is like to deal with non-professionals and people that don't have a clue and have no medical background when you are trying to get relief for your patients. Most of his patients are very sick and require dialysis. He had a patient he put on dialysis two

times a week, Mondays and Thursdays. On Sunday the patient became toxic, had to be raced to the emergency room for emergency dialysis. It happened again the following week. The patient came back to my husband. My husband quite correctly—it doesn't take a genius, even I could figure this out—decided that the patient needed three scheduled dialysis treatments per week. My husband wrote out the appropriate order, sent the patient down to the dialysis unit. The dialysis unit checked with the insurance company. Some idiot 3,000 miles away that has never been to a medical school of any kind denied it, denied the third treatment. When my husband called up to see what the problem was, this bureaucrat CEO with not a shred of medical experience says to him, "The diagnosis doesn't call for three dialysis treatments." And my husband, being the diagnosing physician, was a little bit surprised at that analysis.

I think half of the problems, if not more, that we are experiencing in our health care crisis nationally is because we have turned over medical decisions to people that have never been to medical school and don't have a clue. So I would be very opposed to that provision.

We have in Nevada a tremendous nursing shortage, particularly troubling since Nevada has the lowest nurse-to- population ratio in the Nation. There are 520 nurses per 100,000 people in Nevada compared to a national average of 782 per 100,000. This situation, of course, is compounded by the extraordinary growth and the continual bringing on line of new hospitals in southern Nevada. The VA in southern Nevada has an 11 percent nurse vacancy rate. And I know that the VA is actively recruiting. A very concerning issue for us is that the average age of our nurses in the VA, at least in southern Nevada, is 53 years old. With 54 percent of our nurses approaching retirement, the VA desperately needs incentives to encourage nurses to delay retirement.

Now I have got a wonderful community college in southern Nevada and a wonderful university, both have strong nursing programs with long waiting lists. A lot of people are anxious to get in. We have a tremendous shortage in the community and yet we don't have enough sections, we don't have enough spaces to accommodate all of the people that wish to go to nursing school. When you talked, Secretary Mansfield, about possibly building some sort of relationship or working on this, what are you suggesting because I would like to know so that we can perhaps expand our programs in Nevada and produce the nurses that we need, not only for the community and the VA as well. And we are going to need it big time in a couple of years, as you are well aware.

Mr. MANSFIELD. You are exactly right, and I mentioned earlier that Dr. Bolton in presenting a draft nursing commission report had indicated that they were going to call for the same type of relationship that we have with medical schools with nursing schools is one of the issues that they are looking at. And they made the point that there are 11,000 people that would like to go to nursing school that there aren't slots for now.

Ms. BERKLEY. Right.

Mr. MANSFIELD. And we need to be working on that issue in an attempt to get more folks involved in——

Ms. BERKLEY. That is my question, how are we working—what do you suggest——

Mr. MANSFIELD. Well, I thank—excuse me.

Ms. BERKLEY. No, go ahead.

Mr. MANSFIELD. I think, as I mentioned, when that nursing commission report is finalized and we take the report and look at it, we will be coming forward with some suggestions. And I am sure that we will be looking at these types of areas as ones that we will be discussing with the staff and with the Members here on how we should go forward. I have to tell you that 11,000 number just floored me. I had no idea about that. And to have it presented, it is pretty obvious what we need to do I think. We need to work on that.

Ms. BERKLEY. Your CARES Commission study, when will this study be available?

Mr. MANSFIELD. Soon.

Ms. BERKLEY. In my lifetime? During my service in Congress, perhaps?

Mr. MANSFIELD. I don't want to relate it directly to the CARES Commission, but it will be soon.

Ms. BERKLEY. Excellent. Well, I will look forward to seeing that if you can get me a copy when it is completed. And I would like to suggest to you that we might be able to enhance the programs that already exist in southern Nevada and then feed them into the my new VA facilities, which would be a win/win for everybody.

So thank you very, very much and it is a pleasure to see you all again. And I also have a prior commitment that I am already late to, so I will be leaving you as well. But thank you for everything you do.

Mr. MANSFIELD. We will put you on the first delivery list.

Ms. BERKLEY. I am counting on that.

Mr. SIMMONS. Thank you. It is my understanding that Mr. Murphy has no additional questions.

Mr. Ryan?

Mr. RYAN. Thank you, Mr. Chairman. I first want to thank all of you for your service. I am always impressed with the depth of intelligence and your understanding of all of these issues. And they really are I think with everything that is going on with the war now, the VA is becoming more and more, is getting pushed more and more to the forefront, so thank you very much for all that you do. I also have an Armed Services markup in 5 minutes so I will be leaving as well, and I apologize in advance.

I wanted to just ask you, Mr. Secretary, on this selection process, and I apologize if I missed something that has already been covered here, but on the selection process now with the formal search committee and the 18 months, can you just kind of walk me through. I know there are appointments and things that are going on. Can you just kind of walk me through how that works?

Mr. MANSFIELD. The process is pretty much outlined in statute and the VA as normally we would do as a regulation or a set of processes and we are involved in that now. The first issue is for the Secretary to put a commission together. That means that you have to look at the requirements, including as mentioned, the members of the VSOs, the medical education community, DOD,

which is a partner, folks from other parts of the health care industry and other people associated with the VA, a past Under Secretary or a past chief medical director as a part of the process would come in to be part of that.

And then right now, have we sent the letters out? We have notified 11 people that they will be the commission and that commission then will go through a process of meetings once we get the material. But we have also had to advertise in journals and in various places to get the applications in. And then those applications have to go through an administrative process to ensure that the person involved qualifies for the statutory requirements that the job has. Then those applications are distributed to the commission members. They get a chance to look at and review them. From there they go to a decision to interview some or all of the applications and then you go through a process to grade and select. And then you wind up with three names being submitted to the Secretary from the commission. The Secretary then transmits those names to the President.

Mr. RYAN. So from the time of a vacancy you send letters out to potential——

Mr. MANSFIELD. Right, the process does not have to take 18 months and the process we are talking about here is a part of a total process that also involves besides the agency's involvement required by statute with the commission, the White House personnel process that has to be gone through and then the Senate's process to get the person through a hearing, a committee vote and a floor vote. So you put the total together and you wind up with things being stretched out.

Mr. RYAN. So you send a letter out and they send back, they have to fill out an application form? And how big is that form?

Mr. MANSFIELD. The letters went out to members of the commission.

Mr. RYAN. Oh, letters of the commission.

Mr. MANSFIELD. That were pre-selected, so to speak.

Mr. RYAN. Okay.

Mr. MANSFIELD. In other words, they agreed that they would serve and the Secretary then made them an official member of the committee.

Mr. RYAN. That doesn't take that long. How long does that take?

Mr. MANSFIELD. Two weeks.

Mr. RYAN. Two weeks?

Mr. MANSFIELD. Two weeks, I think we did it in.

Mr. RYAN. And then that group sits down?

Mr. MANSFIELD. Pardon me?

Mr. RYAN. Then that group sits down?

Mr. MANSFIELD. Well, that group doesn't even——

Mr. RYAN. The chairman of the special medical advisory group, the VSOs——

Mr. MANSFIELD. Right.

Mr. RYAN. Now is there a formal meeting where they all sit down?

Mr. MANSFIELD. There will be a formal meeting, but at the same time we are working on getting advertisements in medical journals

and other places to attempt to get the most and the best applications that we can.

Mr. RYAN. Okay, so after you send the—I am just trying to walk through this to see where we can maybe tighten——

Mr. MANSFIELD. Some of this is going on at the same time.

Mr. RYAN. Okay, so you send the letter out——

Mr. MANSFIELD. To the commissioners.

Mr. RYAN (continuing). Inviting them. That takes 2 weeks——

Mr. MANSFIELD. Yes.

Mr. RYAN (continuing). To get out or 2 weeks for a reply from them?

Mr. MANSFIELD. They informally agreed to serve so the letters are going out to the people——

Mr. RYAN. But they have to give you a formal letter back saying I accept?

Mr. MANSFIELD. Yes.

Mr. RYAN. So that whole process takes 2 weeks?

Mr. MANSFIELD. Approximately.

Mr. RYAN. Approximately 2 weeks. Boy, my time is up already, and we are not even—maybe I can see why it takes 18 months. We are only 2 weeks in, that was 5 minutes. We will have to have maybe a private conversation on this.

Mr. MANSFIELD. I would be more than happy to do that, sir.

Mr. RYAN. But we want to work with you to try to tighten this up. This seems like something that is doable, maybe.

Mr. MANSFIELD. Yes, sir.

Mr. RYAN. But we appreciate your efforts.

Mr. MANSFIELD. We would be more than happy to follow up at your convenience, sir.

Mr. RYAN. Thank you very much. Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. I have heard it said that we will probably have democracy in Iraq faster than it takes to get a deputy secretary for health. But that being said, I have a final question for Mr. McClain and then we will move on to our next panel.

Mr. McClain, you serve as the chief legal counsel in the Department of Veterans Affairs, and I have here with me some sample solicitations or vacancy announcements from the VA, Veterans Health Administration. And the one on the top I will use as an example. It is a position of registered nurse. The duty location is Martinsburg, West Virginia. And the qualifications required are BSN, among other things, BSN required. If a person is otherwise trained and qualified to be a registered nurse, certified in the state of West Virginia, applies for this position but does not have the BSN, doesn't have it awarded, and that person is rejected, is that consistent with the law? Is that legally sustainable or might that applicant have some opportunity to take legal action against the VA on the basis of the fact that he or she is certified as a registered nurse, practices in Martinsburg, West Virginia where there are I am told many vacancies but simply does not have that one requirement, which is a BSN?

Mr. MCCLAIN. Mr. Chairman, not having seen the actual announcement that you are talking about, it very well, and I would guess that the announcement may have something to do with a very specialized area of practice, perhaps ICU or after care of some

sort, post-operative or operating room nurse. If that is the case, then perhaps there is a higher qualification for that particular position. But, as Dr. Perlin has said, we have many thousands of positions that do not require the BSN. But I would be glad to, my office would be glad to review that announcement and provide you with further follow up.

Mr. SIMMONS. And I appreciate that and I wasn't trying to put you in a difficult situation, but I guess as a layman I think of Martinsburg, West Virginia, I think that there are many vacancies out there. It may well be that it is obviously hard to get qualified people out there. And I just wonder in my own mind sometimes whether that requirement is a good thing or a bad thing. As you say it might be specific to that very particular job although they are saying many vacancies and it does raise a question, just a common sense question.

We want to thank this panel for their testimony today. The second panel——

Mr. MANSFIELD. Thank you, Mr. Chairman.

Mr. SIMMONS (continuing). Thank you—involves my friend and colleague and a resident of my hometown, the Honorable Linda S. Schwartz, commissioner of the Connecticut Department of Veterans Affairs. Yes, she is here. Linda, welcome. Dr. Andrea Mengel, head of the Department of Nursing, Community College of Philadelphia, representing the American Association of Community Colleges; Ms. Marsha Four, registered nurse, Chair, VA Advisory Committee on Women Veterans; and Mr. Robert Van Keuren, chairman of the VA Advisory Committee on Homeless Veterans.

These individuals have all been requested to present their views on specific bills of interest to them or their organizations. Those five bills have been previously listed. We will continue the same procedure of asking the panel to testify. There is a time limit. If you wish to summarize your remarks, we do have your written statements for the record. Please sit and make yourselves comfortable and perhaps you will proceed in the order that I have suggested. But if you wish to proceed in some other order, I will let you work that out among yourselves. Welcome.

Dr. Schwartz?

STATEMENTS OF LINDA S. SCHWARTZ, COMMISSIONER, CONNECTICUT DEPARTMENT OF VETERANS AFFAIRS; ANDREA MENGEL, HEAD, DEPARTMENT OF NURSING, COMMUNITY COLLEGE OF PHILADELPHIA; MARSHA FOUR, R.N., CHAIR, VA ADVISORY COMMITTEE ON WOMEN VETERANS; AND ROBERT VAN KEUREN, VA ADVISORY COMMITTEE ON HOMELESS VETERANS

STATEMENT OF LINDA S. SCHWARTZ

Ms. SCHWARTZ. Good morning, Mr. Chairman. As you know, I am the commissioner of Veterans' Affairs. And just to give you a little bit of my background about what the discussion today is that I am a registered nurse.

I got my degree in a diploma school of nursing. I was able to go to school to get a degree, a baccalaureate in psychology and I was able to get a master's, not because I had a degree, a baccalaureate

in nursing, a master's in nursing from the Yale School of Nursing because I had a degree in something and I was a nurse.

And let me just say that is a marvelous part about the Yale School of Nursing and that we do have many associate degree nurses come to our school. They are registered nurses. They have a degree. It is an associate degree and they are granted admission to a master's program and become practitioner's.

You have put me in a hard place, though, because I also served on the board of directors of the American Nurses Association, which you know promotes the baccalaureate degree. But these are tough times and 20 years ago I came before the committee to talk about the nursing shortage and we are back again. And the reality of all of this is the largest producers of nursing, who qualify as nurses and follow licensure, are in the associate degree programs. And so I would just ask the rhetorical question, which is better, no nurse or a nurse from an associate degree program? And to me the answer is a nurse from the associate degree program because many nurses are very, very determined to go on to get their baccalaureate degree and to go on to higher studies.

You also put me in a position that I have to—because I am a commissioner and I am in charge of a state Department of Veterans Affairs to just take a moment to thank you for even thinking of us. It is true that the VA has a state veterans home construction program but it is important to pull out of my hat the fact that over 38,000 veterans are being taken care of today in 128 state veterans homes. And most of those are long-term care beds. By the fact that they exist, VA does not have to construct new beds. And so they call it a partnership. And truly I am, actually Connecticut for the very first time is going to be able to be part of that partnership with the state home construction.

One of the other things that we are doing in Connecticut, as you know, is we are working very hard with VA Connecticut to increase the educational opportunities for our nurses. The truth of the matter is, though, nursing homes, the per diem grant program that the VA provides for us allows $57.78 for a nursing home and hospital care and $27.19 for the domiciliary care on per diem basis. Cases are made that many veterans in state homes would be eligible for full support of veterans with service-connected disabilities are rated 70 percent or greater or who may require nursing home care for their service-connected disabilities. Should they be in any other but a state home, they would be reimbursed by VA at a rate of $170 a day. VA's general counsel has ruled that because state homes were constructed using VA dollars, the greater rate for reimbursement does not apply.

I would point out to you that Rocky Hill Veterans Home was not built with VA dollars. We were on the list, we are on a list but I believe the fact that the VA has made this ruling is pejorative to states like Connecticut who created and built their own homes.

And so I would ask that along with considering the upgrade and the consideration of the nursing shortage in homes, you would consider that this is a disparity. We do have many veterans at Rocky Hill which would be required by VA to be placed in nursing homes. And they would then receive $170 a day. We receive $57 for the same care.

I did in my prepared statements call attention to some of the root causes of the national shortage, and I also identified the recent report, "Veterans Home: Nursing Care at the Crossroads," which was a survey conducted by the Armed Forces Veterans Homes Foundation with support from the Kellogg Foundation and namely the demands of the workplace with respect to the great burden of workload, the acuity level of our residents and many of them are chronic disease residents, just as I would like to maybe give you an idea that at Rocky Hill we have everything from homeless, I have 310 homeless in my domiciliary this morning. I have 84 people in a substance abuse treatment program. And I have 169 veterans in our chronic care facility.

So this is quite a spectrum of concerns that a state veterans home would have. An uncertain work schedule, lack of professional development, inadequate support and low pay. Interestingly, the benefits are cited as the most positive reason anyone would work in a state hospital.

As to the proposed legislation, let me just say that as all politics are local, there are variations in needs and solutions to the questions. My first suggestion is that it is a systems issue. And we are making great strides not to duplicate the same services that are provided by VA Connecticut. The idea that H.R. 4020 would offer relief in forms of grants to state homes to affect incentive programs including scholarships to reduce the nursing shortage, has some advantages to the implementation but I see a general difficulty because it is important to note that 88 percent of the states in America already have plans for what they will do about the shortages within the boundaries of their state.

Additionally, just so you know, something very similar to your legislation was proposed to the General Assembly and when I left yesterday, it was pending in the Senate. I don't know how the vote came out.

But it is important that we all look at the fact that the partnership with state homes relieves VA from construction but at the same time counting state home beds in VA numbers is very misleading. Let me just say the costs, the operational costs are borne by the state and any assistance that could be given to these state programs would be in the form of federal support across the board. I did note in my testimony to you, the last line, for veterans in their domiciliary program this year, there was an increase of 24 cents by VA per diem. If you look at that in the long term, what can you buy for 24 cents today? What can you buy for $27.19 when the State of Connecticut values the care that I give those very same people at $90 a day and they are homeless. It is unfair to expect a homeless veteran to be able to pay $90 a day but the $27 is just about all we recoup on the care that we provide.

I want to thank you again for inviting me, for taking state veterans homes into consideration, and I am here to answer any questions you may have.

[The prepared statement of Ms. Schwartz appears on p. 92.]

Mr. SIMMONS. Thank you, Commissioner. Next, Dr. Andrea Mengel.

STATEMENT OF ANDREA MENGEL

Ms. MENGEL. Good morning, Mr. Chairman and members of the subcommittee, I am Andrea Mengel, head of the nursing program at Community College of Philadelphia in Philadelphia, Pennsylvania. Thank you for the opportunity to address the subcommittee and to present recommendations from the American Association of Community Colleges, AACC.

AACC represents 1,173 community colleges which enroll 10.4 million students, 44 percent of all U.S. undergraduates. Community colleges are committed to educating quality nurses and to enhancing the capacity of nursing education programs to address the current nursing shortage. Half of the new registered nurses in the country and 70 percent of the new licensed practical nurses are educated in community colleges.

Mr. Chairman, for more than 50 years community colleges have provided the Nation with RNs who take and pass at the same rate as do RNs with bachelor's degrees the licensure exam that all nursing graduates must pass to practice nursing. Throughout the Nation, RNs who earn their degrees at community colleges are sharing the same responsibilities as they practice alongside their counterparts from bachelor degree programs.

Mr. Chairman, an RN is an RN. A bachelor's degree in nursing does not educate or authorize RNs to provide additional care to patients. Not a single state in the Nation requires RNs to obtain bachelor's degrees to practice, to advance within their careers.

Community college graduates represent a large percentage of nurses of color in the profession and bring a breadth of experience and dedication to the field. Associate degree nursing programs allow students to move forward within the workplace and to be educated more quickly and at lower cost. According to the U.S. Department of Education, on average students pay $1,379 per year in tuition at public community colleges, which are the majority of two-year schools, compared to $3,746 per year in tuition at public four-year institutions. Through the National Nurse Education Initiative, the VHA is spending an average of $11,000 to educate a RN to the bachelor's level. This same funding could educate 3.9 RNs in associate degree programs, thereby providing a workforce of very high quality relatively quickly.

Nationwide health care providers and patients alike value the care provided by RNs educated in community colleges. Surveys of RN employers and of patients themselves have shown no preference for RNs educated in one type of program over another. Data from a recent AACC survey indicates that hospitals and other facilities across the country are collaborating with most community colleges to enable them to expand enrollments in and increase graduations from nursing programs. These health care providers regard RNs receiving their education in associate degree programs so highly that most require those students to agree to serve at their facilities upon graduation in exchange for scholarships and many provide their own nurses, desperately needed to meet patient demands, to community colleges to enable the education of more RNs.

As a lifelong nursing educator, I am very disappointed in the hiring and promotion policy instituted nationwide by the Department

of Veterans Affairs. It is very disappointing that the VHA's hiring and salary progression policies do not value RNs practicing with the associate degree. The VHA's Nurse Qualification Standard is a disincentive to work at the VHA to 60 percent of new RNs as well as to hundreds of thousands of experienced RNs educated in associate degree programs. These RNs, who have achieved licensure exam passage rates equal to those of their bachelor's degree counterparts and have proven to provide quality patient care for over 50 years that cannot be differentiated from that provided by RNs with bachelor's degrees, cannot advance within the nursing profession at the VHA after years of experience as a registered nurse.

Nursing practice outside of the VHA is a better career choice for the well-educated, high-quality, and often experienced nurses who earned their degrees at community colleges. With hundreds of choices of workplace opportunities, why would new RN graduates from associate degree programs choose to work at the VHA where the hiring and promotion policy will hold them back? Community colleges across the Nation report that their graduates are not choosing the VHA. For example, not one of 300 RNs who graduated from Community College of Philadelphia in the past 4 years chose to work in the VA.

To continue to provide high-quality nursing care for patients, AACC recommends that the VHA adopt the following hiring and promotion strategies:

Employ all new RNs entering nursing at the same level; provide promotion opportunities for all RNs based on performance and continuing education in specialty and master's degree programs; support continuing education for all RNs, encourage experienced RNs to work for the VHA; utilize the National Nurse Education Initiative funding and implement a RN to MSN program to address the nursing faculty shortage; expand enrollments of RNs with associate degrees in the Nation's more than 150 graduate nursing programs, such as Yale, that enroll RNs without requiring a bachelor's degree in nursing; create and fund a program to provide opportunities for RNs planning to retire from the VHA to enroll in master's degree programs that will enable them to serve as faculty. A shortage of faculty is preventing nursing programs from expanding enrollments to meet the Nation's need for nurses.

Mr. Chairman, thank you very much for the opportunity to speak here today. I welcome any questions.

[The prepared statement of Ms. Mengel appears on p. 98.]

Mr. SIMMONS. And thank you. And you did a marvelous job, as the red light went on, you came to conclude. I have been following through your written text and you left certain sentences out and it was just terrific. Thank you very much, very interesting testimony and some shocking statistics. Next, Ms. Marsha Four.

STATEMENT OF MARSHA FOUR

Ms. FOUR. Good morning, Mr. Chairman and members of the subcommittee, I want to thank you for the invitation and the opportunity to be here today to address H.R. 3849, the Military Sexual Trauma Counseling Act of 2004. And, as Representative Rodriguez had summarized it earlier, which originated in 1992, with Public Law 102–A585.

As background on some numbers, and as noted, over the next 10 years, the projected number of women veterans will double. Also as a reference point is that in Fiscal Year 2003, the number of women enrolled in the VA was up 9.4 percent over Fiscal Year 2002, for those enrolled. For the women who utilized the VA, it was up 7.5 percent from Fiscal Year 2002. The CARES process also had numbers that relate out into the future on the increase of those statistics.

For a number of years The VA Advisory Committee on Women Veterans has been looking at the temporary, sunsetted, "need to be made permanent" issue for military sexual trauma authority. The Advisory Committee has several recommendations actually, in its our 2004 report that will address the topic of military sexual trauma. Once again . . . again, we are asking for legislation, which the VA has also done this year, to provide VA with permanent authority to provide this military sexual trauma counseling.

The reporting of the screening for military sexual trauma was fully implemented in the VA in March of 2002. Between the dates of March and October of that year, one in 20 women and one in 100 men reported that they had experienced military sexual trauma. Obviously the percentage is lower for men because there are many more men in the VA system. However, the actual numbers indicate that men and women are equal in reporting military sexual trauma.

One item the advisory committee looked at and noted while putting together our report is that, and interestingly, statistics indicate, according to the National Victim Center, that only 16 percent of rape cases are reported. We can never forget this issue when reviewing statistics.

Another is that approximately one-third of rape victims develop PTSD. A 1999 study in the Journal of Traumatic Stress, reported that one in four female VA outpatients reported sexual assault while in the military.

We note military sexual trauma is an event and this event has very far-reaching consequences to the victim including both medical, psychological, and mental health problems. Sexual trauma is associated with suicide, eating disorders, unhealthy relationships, not knowing when to say "no", mood swings, difficulty with anger management, and difficulty with trust.

Interestingly, it might also be a contributing factor in to some incidence of homelessness in veterans. If we look at the report of the VA Northeast Program Evaluation Center, NPEC, study data collected from a cohort of 443 homeless women veterans in the VA Homeless Women Veterans Pilot Program, it is reported that 38 percent of those in that study have been sexually harassed in the military and 43 percent said they had been raped. Startling are other statistics that of all U.S. women, those who served in the military are overall three times more likely to be homeless.

It seems apparent the need is present and it continues for this VA authority. For this reason we come to Congress seeking not only a renewal of the VA authority to provide this service, we ask that it be made permanent. We ask that there never be a question in the minds of the victims that treatment for this trauma is seen only as temporary; that it could go away, it could lapse, maybe for-

gotten. Sexual abuse and rape are despicable, dark, vicious crimes. They attack and tear from us the very security of who we are and the control that we own over our minds and bodies. Sex is a highly charged emotional and hormonal-driven activity that is part of our human process and it is a very powerful motivator.

I think just looking at the reality of this, in today's language, my kids would say, "Let's get real about this." Sexual trauma attacks are not going to go away. They have been around since the beginning of time and they exist in every community, corporation, and culture in this country. It is incomprehensible to think that it would be totally eliminated within the ranks of the military no matter what anyone does. There will always be good people and bad people, perpetrators and victims. No matter how many come forward with a problem, whether it be 50 or 5,050, this problem will always exist. In light of this, we believe the authority should be made permanent, that no matter the number, these victims need and deserve to know that the care and treatment that they need will be accessible. By making the authority permanent, the message is sent that the pain these victims suffer as a result of military sexual trauma is recognized and validated; that access to treatment will always be available regardless of the veteran's VA eligibility. Many veterans don't even know that, regardless of their VA enrollment status, and regardless of what priority category they fit into at the time, this authority further eliminates the veterans' co-payment for treatment and also for prescriptions.

I thank you for providing me the opportunity to be here today and participate in this hearing. Mr. Chairman, this concludes my testimony and I am able to answer questions.

[The prepared statement of Ms. Four appears on p. 102.]

Mr. SIMMONS. Thank you very much. And now Mr. Van Keuren.

STATEMENT OF ROBERT VAN KEUREN

Mr. VAN KEUREN. Thank you, Mr. Chairman and members of the committee. Thank you for the opportunity, again, to appear before you here today and give you some comments.

I would like to limit my comments to H.R. 4248, the Homeless Veterans Assistance Reauthorization Act of 2004. I will tell you I am testifying as the Chair of the Secretary of Veterans Affairs Committee on Homeless Veterans. In addition, I am homeless program coordinator for network VISN–2, Department of Veterans Affairs. My work in assisting veterans has preceded my employment with the VA and has included being executive director of the Vietnam Veterans of San Diego, where I was a cofounder of the National Stand down Program. Additionally, I was co-founder of the National Coalition for Homeless Veterans. As you are aware, the VA Homeless Grant Per Diem Program has added more than 6,000 transitional housing beds in service today and accompanying Per Diem Programs to support those services. An expected 10,000 beds will be in service when the authorization of all those beds comes on lines. It has proven to be a very successful and valuable asset in assisting homeless veterans.

The Advisory Committee supports the proposed increase of the authorization to support this excellent program at the level of $100 million for Fiscal Year 2006 through 2008. Funding at this level

will allow for continued operation and support of the 10,000 transitional housing beds. The Grant Per Diem Program has proved to be an effective and cost-efficient mechanism not only to provide transitional housing to homeless veterans but also as a method to assist faith-based and other community-based agencies to leverage additional resources in support of efforts to assist homeless veterans.

Again, I would like to thank you for the opportunity to come before you and present the views of the Advisory Committee to you and would be willing to answer any questions you might have regarding this.

Thank you.

Mr. SIMMONS. Thank you very much for that testimony.

Let me focus first on Commissioner Schwartz's comments. As I understood the numbers, if a veteran is in a VA facility for long-term care, the cost is $170 a day.

Ms. SCHWARTZ. No, that is how much the VA will reimburse the care.

Mr. SIMMONS. Okay, however, if that same veteran is in a state home, then the reimbursement is $57.

Ms. SCHWARTZ. Yes, sir.

Mr. SIMMONS. Substantially less.

Ms. SCHWARTZ. Yes, sir.

Mr. SIMMONS. Now do you provide that veteran with 24-hour nursing care on call?

Ms. SCHWARTZ. Yes, in fact we in order to get the per diem we are surveyed on a yearly basis, they call it a muster. The VA comes in, they look at all the care that we provide, all of our procedures. So therefore we meet the same standards as any nursing home. And if we don't, we don't get the per diem.

Mr. SIMMONS. And yet as I understand their testimony, they are not willing to pony up dollars to assist you in attracting nurses. What is your comment on that?

Ms. SCHWARTZ. The comment is that we are, as I said in my testimony, we are continuing the care of the veteran. We are doing the work that VA would have to make new nursing homes, would have to create new facilities, so the interface, the continuum of care that I provide at Rocky Hill is actually the respite, the hospice, the Alzheimer's, all of these units are places that VA would have to pay a lot more if they had to provide this.

What I am saying here is that many of our veterans at Rocky Hill meet the requirement of being over 70 percent service-connected disabled or disabilities that are associated with their military service and are acknowledged by the VA. So in actuality the VA is saving $120, around $120 a day by us taking care of them.

But what happens is this does create a problem as far as cash flow, not just for us in Connecticut but across the Nation. Many of the homes have asked, they had requested the additional funding. The ruling of the general counsel of VA is that because those hospitals, those nursing homes were built with VA funding, then they are not eligible for the full $170 a day.

Now what I am saying is that the Rocky Hill was built in 1938. That was long before the State Home Construction. So therefore we did not use VA dollars. They have not invested yet, hopefully. They

have not invested in this. And so the thinking that they are saying is that we helped to build this facility, they did not. And we are not the only state that should be getting $170.

But when you look across the board, what do you get down to? If VA would acknowledge that state veterans homes should receive more of the per diem, the other thing is what does it say when they raise the annual per diem 24 cents a day, why bother? The paperwork alone takes more time, the documentation.

Mr. SIMMONS. That doesn't even cover a quarter of this cup of coffee. It used to be a cigar maybe but no more.

Ms. SCHWARTZ. Yes this is a and working in a partnership? Let me just say more, we at Rocky Hill are changing because many of our veterans, the State of Connecticut was actually buying medications from the VA that the VA could, should and would have if Rocky Hill wouldn't have been able to provide to them for free. So we buy in bulk, we pay a pharmacist to dispense the medications and if this veteran was not in my home, he would be going down to the West Haven VA and getting those medications for free from the VA.

So there is a lot and you have to look forward. You have to look forward to the fact that we have an aging veteran population and the investment that VA has made in the homes that they are rebuilding and refurbishing assures that we will always have veterans in our state veterans homes. And this is something that needs to be really ironed out.

Mr. SIMMONS. Thank you very much. Very briefly, I just wanted to comment on Dr. Mengel's testimony. As I recall, you said that for the amount of money it takes to produce a BSN, you could produce 3.9 registered nurses through an associate's program. Is that correct?

Ms. MENGEL. Correct.

Mr. SIMMONS. And if so, that is a huge efficiency at a time when there is a nursing shortage. That just seems to me to be a stunning figure. And I am also stunned by the fact that not a single one of your graduates went to the VHA over a four-year period. Is that a statement of problems with regard to VHA or is that a statement of problems with regard to your graduates?

Ms. MENGEL. I have never received any recruitment literature from the VA to distribute to the students. They have never approached me or my students.

Mr. SIMMONS. The red light applies to me as well. I thank you for the testimony and I ask my friend, Mr. Rodriguez for his questions.

Mr. RODRIGUEZ. Thank you very much. I want to thank the entire panel for your testimony. Let me just also say, Dr. Mengel, I know that we have had a difficulty also of getting the faculty that is needed and the faculty, especially the doctorates, I guess, in nursing that is required and should be there. There is really a need for us to do something there so I wanted to thank you for the comments on what you have done in that area.

And, Ms. Four, I also wanted to thank you for the research that you have done. I was kind of startled, we don't like to think that we have a lot of homeless women out there. It is not known in terms of the women out there that are veterans that are homeless,

and I was wondering if you wanted to comment about that in terms of the need for research in that area?

Ms. FOUR. I think there is a need in light of some of the statistics that are coming out of the 11 pilot programs that the VA instituted about 3 years ago. Most of them are coming up upon their three year pilot completion, if they are not there and at the end of that evaluation period. NEDEC, the data collection center, has been compiling information from them.

I believe that probably there has not been given full attention to the women veterans that are in the homeless population and looking at fully evaluating military sexual trauma within that population. I spoke with Mr. Pete Dougherty, Director of VA Homeless Programs, this morning and he indicated to me that some of the recent numbers show that, over last year for the homeless stand downs, there is a 40 percent increase in the number of women who are presenting themselves at these stand downs, which is remarkable. Certainly more women are in the military and that is why we are seeing those numbers. I will tell you that with the Grant Per Diem Program, many more programs are able to take care of women veterans. There are very few specifically for homeless women veterans. The advisory committee is looking to a possibility to expanding that out, making part of more of the homeless programs include certain therapeutic modalities that will—(there is one that comes to my mind called "Seeking Safety") allow men and women to address the safety issue of their own security and how they can handle themselves and evaluate situations and gain the ability to go back into the community and not have the results of military sexual trauma control part of their lives any further. But I do think that if we are going to be studying women veterans, any veterans in this regard, even in the male population, we need to look to the homeless veteran situation because I think there may be significant influence in the homeless situation because military sexual trauma.

Mr. RODRIGUEZ. I agree with you that it is not going to get any better any time soon. I was just dialoging with someone this morning when I was drinking coffee and the person said, "Well, I had a friend who actually sent me some pictures, that when he was in the military he was taking pictures of his colleague," and it didn't seem like it was a situation, so it seems like we really have a lot of work to do.

Mr. SIMMONS. Mr. Boozman? Let me ask a second question of Mr. Van Keuren and let me thank you for all of your work for homeless veterans. In your dealing with homeless veterans, how do you differentiate in your dealing with me versus women? Is there an issue there? What we have tried to establish here in legislation is that when it comes to issues of sexual trauma, it seems like we need to pay special attention. But in dealing with women as homeless veterans, do you have any thoughts on that subject?

Mr. VAN KEUREN. I believe clearly that the homeless women veterans present a series of issues, life issues as well as service issues, that oftentimes are significantly different than their male counterparts. I know when we first started the Homeless Veteran Stand Down Program, one of the first issues that surfaced was not having the program focus specifically on the male veterans but the home-

less women veterans who came to the event presented with some unique issues and caused the service delivery system to begin to recognize what some of those issues are.

And I want to follow-up on some of the comments that were just made. The numbers of homeless women veterans that we are beginning to see are increasing, and I believe that the data really isn't truly reflecting the increase at this point because I think that some of the challenges that we face with outreaching to the homeless women veterans, where we do the outreach, and how to go about engaging them with services and treatment. So I know that the Advisory Committee has specifically looked at and liaisoned with the Women's Advisory Committee on the issue of homelessness among women and some of the specificity that the VA may need to apply to some of the programs, particularly one of our recommendations is to extend the pilot programs so that we are able to glean a better understanding.

But to put a simple point on your question, I don't believe, and my personal experience in doing this for quite a while that you can have a program for homeless women without addressing not only the needs of sexual trauma but the needs of family, family unification in many cases, and it is certainly the case where we are finding more and more single parents that are women in the homeless population. So while the VA may not in and of itself be able to provide services to the children, it is incumbent upon us to work with the nonprofit and other community-based and faith-based organizations so that we can partner to create those types of services.

Mr. SIMMONS. Commissioner Schwartz and then after this comment we will go to the next panel.

Ms. SCHWARTZ. Okay, I just wanted to say that at Rocky Hill we have had an increase, when I came we had five women veterans, today we have 20. That is in 10 months. And the issue of sexual trauma is a factor in about 75 percent of those cases and that we have really started working with the Vet Center Program and their sexual trauma and with the regional office to assist these. But it is amazing how many women are coming to us and it is also stunning how many of these women have sexual trauma associated with military service is a factor in their lives.

Mr. SIMMONS. I want to thank all of our panelists for appearing this morning. I am told that we will be having votes some time between 12:00 and 12:30 today so I want to move quickly to the third panel to give them an opportunity to get their comments on the record. Our third panel represents national veterans' service organizations and our witnesses are Ms. Cathleen Wiblemo, deputy director of health care, Veterans' Affairs and Rehabilitation from the American Legion; Mr. Rick Weidman, director, Government Relations, Vietnam Veterans of America; Mr. Richard Jones, national legislative director of AMVETS, Mr. Richard Fuller, national legislative director, Paralyzed Veterans of America; and Mr. Dennis Cullinan, national legislative director, Veterans of Foreign Wars, oh, yes and Mr. Adrian M. Atizado, assistant national legislative director, Disabled American Veterans. A very substantial panel. Our table is almost too small. Again, given the fact that we anticipate votes some time between 12:00 and 12:30, I will ask Ms. Wiblemo to proceed.

STATEMENTS OF CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR, HEALTH CARE, THE AMERICAN LEGION; RICK WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA; RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; RICHARD FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DENNIS CULLINAN, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS; AND ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF CATHLEEN C. WIBLEMO

Ms. WIBLEMO. Thank you, Mr. Chairman. On behalf of the American Legion, I would like to thank Chairman Simmons and members of the subcommittee for this opportunity to present our views today regarding several pieces of legislation affecting the quality of health care for our Nation's veterans.

H.R. 4020, "The State Veterans' Homes Nursing Recruitment and Retention Act of 2004," which would provide incentive programs for nurses at state veterans homes through VA—the American Legion believes the intent of this bill has great merit. However, we also believe that any new program or benefit should be accompanied by sufficient funding that will allow the VA to carry out any program within its scope of responsibility efficiently and effectively and not as an unfunded mandate.

Section 2 of H.R. 4231, "The Department of Veterans Affairs' Nurse Recruitment and Retention Act of 2004," creates a one year pilot program to assess the effectiveness of innovative human capital tools and techniques in hiring and retaining nurses in VA health care facilities. The American Legion believes VA should avail itself of every opportunity to address the current shortage of nurses and we look forward to the establishment of this pilot program.

The American Legion supports Section 3 of this bill that will establish a variety of new alternative work schedules. Flexible work schedules have long been used by the private sector to attract nursing personnel, and we believe this will be a valuable benefit in assisting VA with its recruitment and retention goals.

Section 4 would amend Title XXXVIII, United States Code, to prohibit VA from barring appointment of registered nurses who do not have bachelor's degrees. This particular section appears to target the VA policy plan to hire only baccalaureate level RNs by October 2005. The American Legion understands the desire of VHA to upgrade its professional nursing staff. However, we believe the plan would prove to be counterproductive and would reduce the pool of potential nurse employees at this critical juncture. While we have no formal position concerning this issue, we believe that otherwise qualified RNs should not be precluded from VA employment for lack of a four-year college degree.

Concerning H.R. 3849, "The Military Sexual Trauma Counseling Act of 2004," the American Legion is pleased to support this legislation and we continue to believe it is an absolutely vital service for veterans.

H.R. 4248, "The Homeless Veterans Assistance Reauthorization Act of 2004," extends the authority of VA to make grants to assist eligible entities in establishing programs to furnish, and expanding or modifying existing programs for furnishing outreach, rehabilitative services, and vocational counseling and training to homeless veterans to 2008.

Less than 9 percent of our country's population served in the military and yet 34 percent of our Nation's homeless are veterans. This is certainly an untenable situation. The American Legion strongly supports this legislation for continuing the critical services needed by homeless veterans and we are pleased with the increase in the funding to $100 million.

Finally, the American Legion has some concerns regarding the changes in the appointment process outlined in the draft legislation regarding the qualifications and requirements of the Under Secretary of health. While we have no official position, it is important that we fully understand the intentions of the changes that will take place as a result of this legislation.

Mr. Chairman, the American Legion thanks you and the subcommittee for its continued support for our veterans. While the proposed bills discussed today address specific shortfalls and problems within the VA health care and benefits program, these once again are incremental fixes to a greater systemic problem for VA. Until a consistent funding mechanism is created for VA's health care programs and is in place, the Congress will continue to treat the long list of symptoms plaguing the VA rather than providing it with a cure that will improve the quality of care and benefit programs for our Nation's veterans.

Thank you.

[The prepared statement of Ms. Wiblemo appears on p. 107.]

Mr. SIMMONS. Thank you. Mr. Weidman.

STATEMENT OF RICK W. WEIDMAN

Mr. WEIDMAN. Mr. Chairman, on behalf of Vietnam Veterans of America and our national president, Tom Corey, thank you very much for the opportunity for VVA to offer our views here this morning.

As an overall statement on several of the pieces of legislation pending here this morning, we would point out that the nursing shortage is indeed a national shortage. Bureau of Labor Statistics estimates that over this decade we will need 1.1 million more nurses slots than we currently have today. With an aging general population and an exploding U.S. population, it is coming at a time when more nurses are needed in all kinds of medical facilities. Compounding that is the Baby Boomers retiring or, in many cases, moving on to a less strenuous and less stressful occupation because of the status of the pay and the long hours and the reality of what a nurse does.

VVA would in that regard, by the way, favor pay indexes. The genius of our economy is that when you have a demand that is truly a demand that is larger than the supply, the price goes up. When the price goes up, then the supply will adjust with the demand. We need to take that into account today and when we look

at pay and clinician's pay right across the board within VA, not just for nurses but also for other clinicians, particularly physicians.

In regard to H.R. 4020, "The State Veterans Home Nurse Recruitment Program," we do favor this program. It is a modest step but may in fact help many of the state homes recruit and retain needed nurses. We would point out that because of the dire fiscal straits that many states are in, many states may not be able to take advantage of this program even as it is but it is one that is needed.

H.R. 4231, the nurse recruitment program, once again we would be very much in favor, we are very much in favor of this act. While it was noted earlier today that there are 5,000 nursing vacancies, we urge the committee and the committee staff to look back at the number of nurses, particularly on acute care, in the year 1996 and the number of nurses per veteran census within the VA and you will find that the nurses per capita, the number of patients per each nurse has almost doubled at the VA. They may have 5,000 vacancies on the books but we would suggest that there are many more than that that they should have within the system in order to deliver first class care that is safe for the veterans who are taking advantage of it.

In addition to that streamlined hiring process or streamlined hiring procedures has in fact throughout the Federal Government served as code words for denial of veterans' preference to disabled veterans and veterans who are wartime veterans. We urge that anything that you do in there stress that veteran preference law must be observed and enforced and that managers who violate those earned rights will in fact be held fully accountable.

H.R. 3849, "Military Sexual Trauma Counseling Act of 2004," this is a long overdue Act and we salute Mr. Rodriguez for introducing this legislation to make this program permanent. Seventeen percent of our Armed Forces today are women, as was pointed out earlier, and the sexual trauma effects long term need to be addressed.

We would also suggest with that that you note in there the ability and authority for VA to treat the entire family where the victim of sexual trauma is in fact married because it is treating the entire family that is going to work and not just the individual veteran who has been harmed by virtue of military service in this way.

H.R. 4248, "Homeless Veterans Assistance Reauthorization Act of 2004." The Stewart B. McKinney Act and the municipalities across the country who are receiving funds pursuant to that Act, have put almost all of their emphasis on permanent housing, making it virtually inaccessible to transitional housing money for the community-based organizations that are such an important part of the service matrix to try and help homeless veterans. Therefore this program is even more important than ever, this proposed increase in the authorization, we applaud. We think it is a modest increase and it is very much needed. We ask your help to make sure that all of this is fully appropriated.

The draft bill to reform the qualifications and selection requirements for the position of Under Secretary of health, VVA does not favor this as written, at least the first provision. We believe that the Under Secretary must be a clinician, not necessarily a physi-

cian but must be a clinician and make the deputy Under Secretary whoever they want. We favor the military model. Every medical company, every medical facility in the United States Army or the United States Navy is commanded by a physician or another clinician. And the executive officer is always an administrator, generally in the Army it is the Medical Service Corps who is trained in the logistics and control of the troops, personnel, et cetera, and we believe that that model has been proven and should be adopted by VA.

Insofar as to eliminating the commission and switching it over to an advisory committee, we very much favor that change because we think it will streamline the process in a good way, not a bad way and in order to hold a President or a Secretary accountable, they need to have the latitude to appoint their candidates to key positions such as that.

Last but not least is we would second the statement earlier of the American Legion that you are not going to achieve good clinical care, including getting and retaining nurses until we have an adequate and predictable funding base throughout the system and we would urge action by the Congress on that, Mr. Chairman.

Thank you very much for considering our views.

[The prepared statement of Mr. Weidman appears on p. 111.]

Mr. SIMMONS. Thank you. Mr. Jones.

STATEMENT OF RICHARD JONES

Mr. JONES. Chairman Simmons, Representative Berkley and Representative Boozman, thank you very much on behalf of the commander of AMVETS. We appreciate being here. AMVETS applauds your subcommittee and its efforts to identify and pursue solutions that update and improve veterans' earned benefits. H.R. 4020, "The State Veterans Home Nurse Recruitment Act," introduced by Chairman Smith would establish a program to enhance state employee incentive programs used to recruit and retain quality nursing staff. We know that for many senior veterans, the state veterans home is both first choice and last resort for those veterans no longer able to fight life's battles alone. In many cases, the homes offer nearly everything from independent living to skilled nursing care. AMVETS supports H.R. 4020 and we wish the subcommittee to understand that we will continue to support legislation that holds the potential to improve VA's response to the care needs of an aging veterans population.

H.R. 4231, "The Department of Veterans Affairs Nurse Recruitment and Retention Act," introduced by Chairman Simmons, seeks to authorize a set of new initiatives which aim to attract and retain nursing personnel at the Department of Veterans Affairs. AMVETS agrees the VA needs to do all it can to recruit the nurses necessary to provide quality, timely care to America's veterans. As today's nurses retire, VA must be in position to stave off nursing shortages. H.R. 4231 has the potential to help VA update and upbeat a more aggressive recruiting effort to reach the marketplace with more modern tools. AMVETS supports H.R. 4231.

H.R. 3849, introduced by Ranking Member Rodriguez, would permanently extend VA's authority to offer counseling services to women experiencing sexual trauma while serving in the Armed

Forces. AMVETS clearly sees a need for making this program permanent. We agree the VA and the Federal Government should give increased attention to the problem of sexual assault in the military. Last February, the Denver Post reported that dozens of women in combat zones were returning from deployment seeking sexual trauma counseling and reporting sexual abuse by fellow soldiers. While it is our understanding that officials at the Pentagon are finalizing a report to respond to these concerns, victims of sexual assault need present support and current options. In this regard, we believe this military could do a better job providing services to victims of sexual assault. At the same time, VA stands for those veterans and AMVETS supports H.R. 3849 and supports the provision of counseling support to veterans suffering from the ill effects of sexual trauma.

H.R. 4238, "The Homeless Veterans Assistance Reauthorization Act," introduced by Chairman Smith would extend VA's grant-making authority and provide assistance to the programs which aid homeless veterans. Without this legislation the authority for the program would expire in September 2005. The bill also increases the grant per diem program spending limit to $100 million from $75 million. Bringing homeless veterans in off the street and empowering them to become productive individuals is a goal of AMVETS. AMVETS strongly supports this bill.

Mr. Chairman, we applaud you for holding this hearing. We thank the subcommittee for extending us the opportunity to present our views on these matters and again thank you very much.

[The prepared statement of Mr. Jones appears on p. 117.]

Mr. SIMMONS. Thank you. Mr. Fuller.

STATEMENT OF RICHARD FULLER

Mr. FULLER. Mr. Chairman, thank you for the opportunity to testify on behalf of Paralyzed Veterans of America. I would like to submit my entire statement for the record. At the same time I want to spend my oral time speaking on the draft legislation on the VA Under Secretary for Health because if I read the body language of this subcommittee right now it appears that you all are about to make a very serious mistake in our opinion.

There are three sections to this which are going to be eliminated from the current statute. First, the draft bill would remove the requirement that the candidate for Under Secretary be a physician. After a lot of discussion in house, PVA has no argument with this change but we ask you to look at that very carefully.

The other two provisions in the draft legislation making major changes to Section 305 of Title XXXVIII U.S. Code we strongly oppose. One provision would eliminate the requirement that the Under Secretary serve for a specific four-year term and leave the individual's service term open ended. PVA believes that the four-year term requirement serves a very valuable function. Under current law, once the Under Secretary has served the four-year term, that individual wishing to continue service must be reconfirmed by the United States Senate. The advice and consent of the Senate Committee on Veterans' Affairs and the Senate as a whole provides additional oversight over the conduct of the Under Secretary. The

re-confirmation also provides an opportunity for others with interest in the operation of the Veterans Health Administration and its chief administrative officer to have the ability to opt into this process too and revisit the qualifications and track record of this individual. Paralyzed Veterans of America had a very specific experience with one of the last Under Secretarys for health when he came up for a four-year re-confirmation period and it was very beneficial for us.

At any point in time prior to the end of the four-year term or after the re-confirmation, the Under Secretary always and still serves at the pleasure of the Secretary and the President. So that means that the Under Secretary can be removed by the President at any point in time. The four-year term has no effect over that at all. But just as the initial confirmation at the beginning of the Under Secretary's term serves as an outside objective oversight function, so does this four-year end of term look back process let the officeholder and all others know that the position is beholden to more than just one Secretary and more than just one White House.

For many of the same reasons we opposed the provision in the draft bill that downgraded the role of the appointment commission established in Section 305 and then relegated it only to an advisory position. Under current law, once there is a vacancy in the Under Secretary's position, the Secretary of Veterans Affairs is required to appoint this commission. Indeed, shortly after Dr. Roswell left, that process has already begun, the commission has already been appointed, it is already working. The commissioners are then called on to screen all candidates for the job and select three of the top candidates and forward those names to the White House.

We are convinced today as those who created this process in the original legislation that the selection of the Under Secretary, because of that individual's direct role over the health and well-being of millions of veterans, must be as objective as possible. The individual must be chosen on the merits without even with a hint of political considerations. The commission was treated as a buffer to isolate the political process from the selection process by allowing the commissioners to screen and actually select the core candidates.

We have no qualms about Deputy Secretary Gordon Mansfield's and Secretary Principi's intentions, their ability and sincerity in choosing basically on their own, if they could, a candidate for submission to the White House who would certainly meet all the qualifications we could expect in an Under Secretary for Health. We know, as well, that they would consult with the veterans organizations as they have always done in the past on major decisions—but who knows what lies down the road in a future Administration and with a future Secretary of Veterans Affairs. An advisory commission as called for in the draft could only be window dressing with no counterbalance whatsoever at all in a future Secretary's choice or in the choice of some future White House seeking appointment by purely partisan objective or potential preconceived disinterest in the mission of the VA health care system.

The Secretary has already appointed the commission to begin to fill this current vacancy and that process is underway. The com-

mission should be able to make its first cut in the selection process to happen at the beginning of the process and not in some consultative role after the fact. We believe the commission is very important and we strongly urge the subcommittee not to change its role in this process.

I would just like to add, Mr. Chairman, as being one of the old timers here who was around when these provisions were put into place that there was a reason for it. It was basically an account of the fact that there had been a certain amount of mischief previously in the appointments of what were then called chief medical directors. Indeed throughout history, and I would imagine even within the Department of Veterans Affairs there have been people who have been appointed to very high positions not because of what they knew but who they knew. We have even had Secretaries of Veterans Affairs who have been appointed who were in that particular situation.

So there seems to be no consensus here among all these different organizations. We appear to be all over the place for some strange reason. But from PVA's standpoint, I think that we would just like to make this point as clear as possible. We hope that the staff present would take that back to their Members as well.

I am sorry I went over my time.

[The prepared statement of Mr. Fuller appears on p. 124.]

Mr. SIMMONS. Thank you very much, and I appreciate your spending all of your time on that particular item because, again, this is a proposal and this is a hearing. That is what this is all about. We appreciate it.

Mr. FULLER. I appreciate the opportunity.

Mr. SIMMONS. Mr. Cullinan? Mr. Cullinan, excuse me.

STATEMENT OF DENNIS CULLINAN

Mr. CULLINAN. Mr. Chairman and distinguished members of the subcommittee, thank you very much. On behalf of the men and women of the Veterans of Foreign Wars and our Ladies Auxiliary, we want to thank you for inviting our participation in today's important hearing.

The VFW strongly supports H.R. 3849, "The Military Sexual Trauma Counseling Act." The sexual trauma program is one of VA's many successes. It compassionately cares for veterans who have suffered from the aftermaths of this trauma. It provides such victims with a safe environment to help them understand what has happened and to help them deal with the complex and life-changing psychological effects of these traumas. It should be made permanent.

The VFW also supports H.R. 4020, "The Senate Veterans Home Nurse Recruitment Act." Long term care is an essential part of VA's mission to provide the full continuum of care to this Nation's veterans. State nursing homes have served an increasingly integral part in VA's attempt to fulfill this mandate. This legislation will further this important role.

We are also pleased to support similar legislation, H.R. 4231, "The Department of Veterans Affairs Nurse Recruitment and Retention Act." It differs from the previous bill in that this legislation focuses more on increasing nursing staff at VA facilities and we

create a pilot program and a VISN that faces a shortage of qualified nurses. It may provide answers to the shortage problem which could be applied system wide.

The VFW is pleased to offer our strong support for H.R. 4248, "The Homeless Veterans Assistance Reauthorization Act." This legislation builds off of 2001's Homeless Veterans Comprehensive Assistance Act. This bill is in the service of our silent veterans. We do not see them everyday and they do not have a powerful voice as constituents. We and the Congress must stand up for them and this piece of legislation serves in that regard.

The final bill under consideration today that I will address is the draft legislation that would change the qualification, amend the qualifications for VA's Under Secretary of health. Chiefly, this important legislative initiative would eliminate the requirement that the Under Secretary be a medical doctor. Additionally, it would eliminate the position's four-year term and change the status of the appointment committee.

While we would expect that the Under Secretary would have some experience in medical settings, his or her skills as an executive must be a primary concern. The size and scope of the VA health care system, as well as the diversity of staff and locations require an exceptional manager possessing extraordinary skill and commitment. It is paramount that there be no impediment to seeking out and securing the best possible individual to serve in this capacity.

We also believe that this draft bill section providing for the elimination of the four-year term represents an improvement and safeguard. This would give the Department the ability to more appropriately and readily react if the Under Secretary is not performing up to standards, objective or otherwise. Further, it reduces some of the complications that could arise if the Under Secretary need be removed from office for not properly or fully fulfilling his or her duty. We do not support reducing the role of the appointment committee to mere consultative role.

I would agree with my colleague from the Paralyzed Veterans of America, while the current Secretary and for that matter the Deputy Secretary would be fully responsive to our concerns, some future Secretary could indeed not be as informed or as appreciative of our efforts and it is for that reason that we oppose this change.

Mr. Chairman, that concludes my statement.

[The prepared statement of Dr. Cullinan appears on p. 134.]

Mr. SIMMONS. Thank you very much. And now Mr. Atizado from the DAV.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Thank you, Mr. Chairman and members of the subcommittee. I would like to thank you for the opportunity to provide the subcommittee of the views of Disabled American Veterans on legislation under consideration in today's hearing. One measure, H.R. 3849, "The Military Sexual Trauma Counseling Act of 2004," if you will remember in 1995 the Department of Defense conducted a large study of sexual victimization among active duty population. The study found rates of sexual harassment to be 70 percent among women and 38 percent among men over a one year period.

While the rates of attempted or completed sexual assault were 6 percent for women and 1 percent for men, the rates of military sexual trauma among veteran users of the VA health care appeared to be even higher than in general military populations.

The passage of Public Law 102–585 authorized VA to include outreach and counseling services to women veterans who experience incidents of sexual trauma while they served on active duty in the military. Public Law 103–452 later amended this law for VA to provide counseling to men as well as women. Having been extended three times, this bill would make permanent the authority of VA to provide sexual trauma counseling to veterans and ensure the availability of such services now and into the future. Therefore DAV supports this legislation and we urge the subcommittee to report this bill for consideration by the full committee.

H.R. 4020 and H.R. 4231 seek to address issues surrounding recruitment and retention of nurses to provide needed medical care to our Nation's veterans. While DAV does not have a resolution on these two particular measures, DAV believes that nurses are part of the basic framework and nucleus for the provision of health care services to veterans. As the purposes of these measures appear beneficial, we would not oppose favorable consideration by the subcommittee.

H.R. 4248, "The Homeless Veterans Assistance Reauthorization Act of 2004," would extend for four years VA's authority to make grants and increase annual appropriation for such grants to assist homeless veterans. DAV believes in making a difference in the lives of homeless veterans across the Nation. And one of our top priorities is to help break the cycle of poverty, isolation, and move homeless veterans from the streets to self-sufficiency. We understand that VA's partnership with other homeless service providers is directly affected by the Homeless Providers Grant and the Per Diem Program. Accordingly, DAV supports the passage of this important legislation, which provides VA the necessary resources to combat homelessness.

In regard to the last bill under measure, the pending draft bill under consideration, this proposes to reform the qualifications selection and nomination requirements for the position of VA Under Secretary of Health. DAV does not have a resolution on this issue. However, we are concerned that the purpose of eliminating—I am sorry, we are concerned that the proposed elimination of a search commission would eliminate a critical element in the process of selecting and recommending an individual to such an important position. Careful consideration, interaction and discourse among a selected group of individuals are necessary for making a well rounded decision, similar to the function of the subcommittee. Replacing the deliberation process within the commission with mere consultation with those who might otherwise be part of a search commission is serious cause for concern for the Disabled American Veterans.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions.

[The prepared statement of Mr. Atizado appears on p. 139.]

Mr. SIMMONS. Thank you very much. As you may have noticed, my minority colleagues have departed but I have committed to ask a question on their behalf which I will ask now so I am sure not

to forget it. And I will read it as it has been presented to me. This is addressed to each VSO. "We want to make sure that each VSO does make comments on the draft bill. It may be that the subcommittee will mark the bill as drafted next week. Is the current selection process flawed and, if so, have we proposed the appropriate remedies to address these flaws?"

That being said, I note that two VSOs have not taken a position and the other VSOs have testified in a variety ways. This is the question that I have been asked to pose. I will also share with the panel as the original drafter of the proposal, I most likely will not offer it next week because I think some very legitimate questions have been raised. But should we do that, and I suspect we won't, again my minority colleagues have asked I think in particular the Legion and the AMVETS that they see if they can come up with a position on this.

Let me ask my question of Mr. Fuller, again thanking him for his detailed response and let me extend the question to all members of the panel. As I have described the problem, and where did we put the chronology? As I have described the problem, the current process can take up to 18 months to get a resolution. I appreciate all of the comments that have been made. Back in 1993, the commission was established on March 22, 1993. In July of 1993, the Secretary's recommendation to the President was made. From July to November, the recommended candidates, some of them withdrew from consideration. It was not until March 3, 1994 that the Secretary's recommendation was made to the President. That was the second recommendation and so on and so forth. I think we see the problem.

All things being equal, should we be considering a specific time frame? In other words, should the processes as described be tightened up with benchmarks on the VA for convening the commission and submitting the recommendations. I realize it is almost impossible to place a benchmark on the Congress. The Congress moves according to its own dictates and judgments. But would that be something that we should factor into this process as well? Does anyone have any thoughts on that?

Mr. FULLER. Mr. Chairman, I believe that there is some necessity to get some nudging going on within this process. On the one hand I would prefer to wait 18 months to get the good, the right Under Secretary for Health than to have somebody stuck into the position, expedited in a certain way, who is not the right person for the job. I think that the story of the 18 months can be blown out of proportion and would like to know how much of that time was due to foot dragging on the part of the commission and how much of that was recalcitrance in the White House personnel office and their particular procedure. As we know the United States Senate doesn't move very swiftly on things of this nature as well.

So I am just concerned that if we take this all away and turn the process back into allowing the Secretary to go out on his own and pick somebody that we lose the expertise of the commission in being able to go out and put the advertisements in medical journals and beat the bushes and do all this kind of stuff to make sure they can attract the right people. The Secretary is under no obligation to do any of that. The Secretary can go out and say the White

House wanted me to pick so and so, and so I am going to send so and so up. And the Chairman of the Senate Committee is in the same party of so and so and doesn't want to rule against the White House nominee and so the person gets through with very little consultation on our part.

Mr. SIMMONS. In the example that I cited, it was the Executive Branch that essentially took a year to make the recommendation to the President. That recommendation process began March 22, 1993 and ended March 3, 1994. Then that person was confirmed in September of 1994, which was about 6 months later. So in fact the executive process took twice as long as the legislative process. That is rather extraordinary.

Mr. FULLER. I am not sure there is anything we can do about that right now.

Mr. SIMMONS. We have always felt that the legislative process should not be efficient but it should be equitable. It should focus on fairness but in this case it was the executive department for which dispatch is a value that took twice as long as the legislative. And so that is why I put before you the idea that again should the Executive Branch be required to move more quickly? That is not something that we have addressed in the bill specifically.

Mr. CULLINAN. Mr. Chairman, I would ask to speak to that briefly. In a perfect world we could in fact require the Executive Branch to come forward with the proper choice in an expeditious manner but my experience, I have been around awhile myself, and that is just not going to happen. I think it also highlights the problem in basically attempting to benchmark or establish time standards for finding, for seeking out and finding the right individual to serve in the capacity of Under Secretary for Health.

It would be wonderful if we could do it but I don't think that it is possible and to sort of have an overlay of time standards on this process would most likely do more harm than good.

Mr. SIMMONS. Thank you. Anybody else?

Ms. WIBLEMO. Yes, I would just like to address to the best of my ability right now the question on our position with the draft legislation. First of all, the fact that the Under Secretary has to be an M.D., we don't have an argument against taking that requirement out of there. We have serious concern with the fact that the commission has been, appears to have been downgraded to a consultive body. Although we don't have an official position on that, and I would request that we could maybe answer this in writing in more detail to the subcommittee, this question. And, third, the four-year appointment, again, I would have to defer to answering it hopefully in more detail to the subcommittee in writing.

Mr. SIMMONS. We would appreciate that. Thank you.

Mr. WEIDMAN. Mr. Chairman, the four-year term Mr. Fuller raises an interesting question and that could be solved, frankly we believe almost all of the four-year terms over in VHA need to be eliminated. People need to be held accountable by the Secretary on a daily basis. And, secondly, when it comes to the Under Secretary, the point is very valid so that any confirmation position, should there be a second term for a President that every darn one of them needs to be resubmitted for full confirmation hearings. And since

the background checks, et cetera, will have already been done, that can be handled in an expeditious fashion.

The next thing is the idea of time lines is an excellent idea.

And last but by no means least among clinicians you can find some of the best administrative/leaders across this country who are bold, who have a vision, and who can impart that vision and inspire their people and inspire the political support necessary in order to accomplish and realize that vision. The State of Connecticut is a case in point. And so it should be a clinician in our viewpoint and then have your executive officer be the person who strengths have to do with finance and logistics and control, et cetera.

I might also ask and suggest respectfully to the Chair one tactic or procedure within this committee that you have used very successfully on many other pieces of legislation is to put together a roundtable with the veterans organizations and other stakeholders where these matters can be discussed in a semi-formal manner and that way you get much more consensus and I think often much better legislation consideration and then still obviously have a formal hearing to consider whatever comes out of that. So I would recommend that to you, if I may, sir.

Mr. SIMMONS. Any other comments? Yes, Mr. Fuller?

Mr. FULLER. Just very briefly, Mr. Chairman, I would like to comment on this. There seems to be some confusion about this four-year term that people think that it isolates the officeholder from criticism or penalty or whatever is absolutely not the case. The four-year term does not mean that he has a contract to serve that four-year term. The individual can be let go, fired, asked to resign at any point at the pleasure of the President of the United States and we have seen instances of that in the past. So the four-year term doesn't do anything to insulate the person from criticism or administrative action.

Mr. SIMMONS. Thank you. The term "clinician" has been used. The requirement, I believe, is for a medical doctor, so that would not include, as I understand it, a registered nurse or a practitioner. And Mr. Weidman made the remark about our commissioner of Veterans' Affairs in Connecticut, who I believe is a registered nurse. I believe she is a Vietnam veteran. I believe she has her doctorate from Yale University. I believe she is the first woman to be the head of a Department of Veterans Affairs in Connecticut, maybe one of the first in the country but she is not qualified for this position. Is that correct? So under no circumstances could she be appointed to this commission, to this position?

That is sort of what I am looking at is perhaps broadening the scope of those folks that we can look at and maybe we should not open it totally and completely but certainly open it to the point of a clinician under the circumstances that I have just described seems to me to allow a wider group of qualified personnel to apply for that job or be recommended for that job.

Mr. WEIDMAN. Restricting it to only one clinical discipline would seem to us to be an arbitrary barrier. We do think it is important that people who have engaged in major decision-making having to do with patient care and have that firsthand experience is vital to whoever is Under Secretary but don't believe it ought to be a physi-

cian only, that that is an artificial barrier to many good candidates just as a height requirement would be a barrier to some wonderful candidates.

Mr. CULLINAN. Mr. Chairman, I would just add to that.

Mr. SIMMONS. Yes.

Mr. CULLINAN. It seems to us that it would only be to everyone's advantage to open up the entire universe of potential managers to run the VA health care system. Part of our responsibility in the veteran service community, part of the responsibility of Congress and the Executive Branch is to then make sure that we get the right person with the requisite administrative and managerial skills as well as the appropriate medical background if need be and empathy towards the situation of sick veterans. But to say artificially that, no, it is only open to doctors or even only doctors and nurses, why put that impediment in place?

Mr. SIMMONS. Any other comments for the good of the order? Oh, excuse me, Mr. Boozman?

Mr. BOOZMAN. I don't have any questions. Again, I really do appreciate your all testimony. The purpose of these hearings and you all are veterans and you are veterans of many of these hearings. In fact, Mr. Fuller had mentioned one of the things I think that you really bring a value is the institutional knowledge of fighting these battles over the years and discussing these things for several years. So I appreciate your testimony and it was well thought out and certainly brought some things to the table that I hadn't thought of until the discussion. So I do appreciate it. Thank you.

Mr. SIMMONS. Thank you for those comments. I thank all of our witnesses for coming today. I will ask the subcommittee staff director in consultation with the minority staff director to put together a roundtable discussion with the VSOs on this subject and we will proceed with that recommendation. I thank you for your testimony on all the legislation before the subcommittee. There will be I believe a markup on some of these bills next week. I hope so. But on this particular subject we will have the roundtable first.

Thank you all very much and have a nice day. This legislative hearing is adjourned.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

APPENDIX

I

108TH CONGRESS
2D SESSION

H. R. 4020

To amend title 38, United States Code, to establish within the Department of Veterans Affairs a program to assist the States in hiring and retaining nurses at State veterans homes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 24, 2004

Mr. SMITH of New Jersey (for himself and Mr. EVANS) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to establish within the Department of Veterans Affairs a program to assist the States in hiring and retaining nurses at State veterans homes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "State Veterans Home Nurse Recruitment Act of 2004".

SEC. 2. ASSISTANCE FOR HIRING AND RETENTION OF NURSES AT STATE VETERANS HOMES.

(a) IN GENERAL.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1743 the following new section:

"§ 1744. Hiring and retention of nurses: payments to assist States

"(a) PAYMENT PROGRAM.—The Secretary shall make payments to States under this section for the purpose of assisting State homes in the hiring and retention of nurses and the reduction of nursing shortages at State homes.

"(b) ELIGIBLE RECIPIENTS.—Payments to a State for a fiscal year under this section shall, subject to submission of an application, be made to any State that during that year—

"(1) receives per diem payments under this subchapter for that fiscal year; and

"(2) has in effect an employee incentive scholarship program or other employee incentive program at a State home designed to promote the hiring and retention of nursing staff and to reduce nursing shortages at that home.

"(c) USE OF FUNDS RECEIVED.—A State may use an amount received under this section only to provide funds for a program described in subsection (b)(2). Any program shall meet such criteria as the Secretary may

prescribe. In prescribing such criteria, the Secretary shall take into consideration the need for flexibility and innovation.

"(d) LIMITATIONS ON AMOUNT OF PAYMENT.—(1) A payment under this section may not be used to provide more than 50 percent of the costs for a fiscal year of the employee incentive scholarship or other incentive program for which the payment is made.

"(2) The amount of the payment to a State under this section for any fiscal year is, for each State home in that State with a program described in subsection (b)(2), the amount equal to 2 percent of the amount of payments estimated to be made to that State, for that State home, under section 1741 of this title for that fiscal year.

"(e) APPLICATIONS.—A payment under this section for any fiscal year with respect to any State home may only be made based upon an application submitted by the State seeking the payment with respect to that State home. Any such application shall describe the nursing shortage at the State home and the employee incentive scholarship program or other incentive program described in subsection (c) for which the payment is sought.

"(f) SOURCE OF FUNDS.—Payments under this section shall be made from funds available for other payments under this subchapter.

"(g) DISBURSEMENT.—Payments under this section to a State home shall be made as part of the disbursement of payments under section 1741 of this title with respect to that State home.

"(h) USE OF CERTAIN RECEIPTS.—The Secretary shall require as a condition of any payment under this section that, in any case in which the State home receives a refund payment made by an employee in breach of the terms of an agreement for employee assistance that used funds provided under this section, the payment shall be returned to the State home's incentive program account and credited as a non-Federal funding source.

"(i) ANNUAL REPORT FROM PAYMENT RECIPIENTS.—Any State home receiving a payment under this section for any fiscal year, shall, as a condition of the payment, be required to agree to provide to the Secretary a report setting forth in detail the use of funds received through the payment, including a descriptive analysis of how effective the incentive program has been on nurse staffing in the State home during that fiscal year. The report for any fiscal year shall be provided to the Secretary within 60 days of the close of the fiscal year and

shall be subject to audit by the Secretary. Eligibility for a payment under this section for any later fiscal year is contingent upon the receipt by the Secretary of the annual report under this subsection for the previous year in accordance with this subsection.

"(j) REGULATIONS.—The Secretary shall prescribe regulations to carry out this section. The regulations shall include the establishment of criteria for the award of payments under this section.".

(2) The table of sections at the beginning of such chapter is amended by inserting after section 1743 the following new item:

"1744. Hiring and retention of nurses: payments to assist States.".

(b) IMPLEMENTATION.—The Secretary of Veterans Affairs shall implement section 1744 of title 38, United States Code, as added by subsection (a), as expeditiously as possible. The Secretary shall establish such interim procedures as necessary so as to ensure that payments are made to eligible States under that section commencing not later than January 1, 2005, notwithstanding that regulations under subsection (j) of that section may not have become final.

○

I

108TH CONGRESS
2D SESSION

H. R. 4231

To provide for a pilot program in the Department of Veterans Affairs to improve recruitment and retention of nurses, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 28, 2004

Mr. SIMMONS introduced the following bill; which was referred to the Committee on Veterans' Affairs

---

A BILL

To provide for a pilot program in the Department of Veterans Affairs to improve recruitment and retention of nurses, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Department of Veterans Affairs Nurse Recruitment and Retention Act of 2004".

SEC. 2. PILOT PROGRAM TO STUDY INNOVATIVE RECRUITMENT TOOLS TO ADDRESS NURSING SHORTAGES AT DEPARTMENT OF VETERANS AFFAIRS HEALTH-CARE FACILITIES.

(a) PILOT PROGRAM.—(1) Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall designate a health-care service region, or a section within such a region, in which health care facilities of the Department of Veterans Affairs are adversely affected by a shortage of qualified nurses.

(2) The Secretary shall conduct a pilot program in the region or section designated under paragraph (1) to determine the effectiveness of the use of innovative human-capital tools and techniques in the recruitment of qualified nurses for positions at Department health care facilities and for the retention of nurses at such facilities. In carrying out the pilot program, the Secretary shall enter into a contract with a private-sector entity for services under the pilot program for recruitment of qualified nurses.

(b) PRIVATE-SECTOR RECRUITMENT PRACTICES.—For purposes of the pilot program under this section, the Secretary shall identify and use recruitment practices that have proven effective for placing qualified individuals in positions that are difficult to fill due to shortages of qualified individuals or other factors. Recruitment practices to

be reviewed by the Secretary for use in the pilot program shall include—

(1) employer branding and interactive advertising strategies;

(2) internet technologies and automated staffing systems; and

(3) the use of recruitment, advertising, and communication agencies.

(c) STREAMLINED HIRING PROCESS.—In carrying out the pilot program under this section, the Secretary shall, at health care facilities of the Department in the region or section in which the pilot program is conducted, revise procedures and systems for selecting and hiring qualified nurses to reduce the length of the hiring process. If the Secretary identifies measures to streamline and automate the hiring process that can only be implemented if authorized by law, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives recommendations for such changes in law as may be necessary to enable such measure to be implemented.

(d) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the extent to which

the pilot program achieved the goal of improving the recruitment and retention of nurses in Department of Veterans Affairs health care facilities.

SEC. 3. ALTERNATE WORK SCHEDULES FOR NURSES.

(a) ENHANCED SHIFT FLEXIBILITY.—Chapter 74 of title 38, United States Code, is amended by inserting after section 7456 the following new section:

"§ 7456a. Alternate work schedules

"(a) APPLICABILITY.—This section applies to registered nurses appointed under this chapter.

"(b) 36/40 WORK SCHEDULE.—(1) Subject to paragraph (2), if the Secretary determines it to be necessary in order to obtain or retain the services of registered nurses at a Department health-care facility, the Secretary may provide, in the case of registered nurses employed at that facility, that such a nurse who works three regularly scheduled 12-hour tours of duty within a workweek shall be considered for all purposes (except computation of full-time equivalent employees for the purposes of determining compliance with personnel ceilings) to have worked a full 40-hour basic workweek. Such a schedule may be referred to as a '36/40 work schedule'.

"(2)(A) Basic and additional pay for a registered nurse who is considered under paragraph (1) to have

worked a full 40-hour basic workweek is subject to subparagraphs (B) and (C).

"(B) The hourly rate of basic pay for such a nurse for service performed as part of a regularly scheduled 36-hour tour of duty within the workweek shall be derived by dividing the nurse's annual rate of basic pay by 1,872.

"(C)(i) Such a nurse who performs a period of service in excess of such nurse's regularly scheduled 36-hour tour of duty within a workweek is entitled to overtime pay under section 7453(e) of this title, or other applicable law, for officially ordered or approved service performed in excess of—

"(I) eight hours on a day other than a day on which such nurse's regularly scheduled 12-hour tour falls;

"(II) 12 hours for any day included in the regularly scheduled 36-hour tour of duty; and

"(III) 40 hours during an administrative workweek.

"(ii) Except as provided in clause (i), a registered nurse to whom this subsection is applicable is not entitled to additional pay under section 7453 of this title, or other applicable law, for any period included in a regularly scheduled 12-hour tour of duty.

"(3) A nurse who works a 36/40 work schedule described in this subsection who is absent on approved sick leave or annual leave during a regularly scheduled 12-hour tour of duty shall be charged for such leave at a rate of ten hours of leave for nine hours of absence.

"(c) 7/7 WORK SCHEDULE.—(1) Subject to paragraph (2), if the Secretary determines it to be necessary in order to obtain or retain the services of registered nurses at a Department health-care facility, the Secretary may provide, in the case of registered nurses employed at such facility, that such a nurse who works seven regularly scheduled 10-hour tours of duty, with seven days off duty, within a two-week pay period, shall be considered for all purposes (except computation of full-time equivalent employees for the purposes of determining compliance with personnel ceilings) to have worked a full 80 hours for the pay period. Such a schedule may be referred to as a '7/7 work schedule'.

"(2)(A) Basic and additional pay for a registered nurse who is considered under paragraph (1) to have worked a full 80-hour pay period is subject to subparagraphs (B) and (C).

"(B) The hourly rate of basic pay for such a nurse for service performed as part of a regularly scheduled 70-

hour tour of duty within the pay period shall be derived by dividing the nurse's annual rate of basic pay by 1,820.

"(C)(i) Such a nurse who performs a period of service in excess of such nurse's regularly scheduled 70-hour tour of duty within a pay period is entitled to overtime pay under section 7453(e) of this title, or other applicable law, for officially ordered or approved service performed in excess of—

"(I) eight hours on a day other than a day on which such nurse's regularly scheduled 10-hour tour falls;

"(II) 10 hours for any day included in the regularly scheduled 70-hour tour of duty; and

"(III) 80 hours during a pay period.

"(ii) Except as provided in subparagraph (i), a registered nurse to whom this subsection is applicable is not entitled to additional pay under section 7453 of this title, or other applicable law, for any period included in a regularly scheduled 10-hour tour of duty.

"(3) A nurse who works a 7/7 work schedule described in this subsection who is absent on approved sick leave or annual leave during a regularly scheduled 12-hour tour of duty shall be charged for such leave at a rate of eight hours of leave for seven hours of absence.

"(d) 9-MONTH WORK SCHEDULE.—The Secretary may authorize a registered nurse appointed under section 7405 of this title, with the nurse's written consent, to work full-time for nine months with three months off duty, within a fiscal year, and be paid at 75 percent of the full-time rate for such nurse's grade for each pay period of that fiscal year. A nurse working on such a schedule for any fiscal year shall be considered a ¾ full-time equivalent employee for that fiscal year in computing full-time equivalent employees for the purposes of determining compliance with personnel ceilings. Service on such a schedule shall be considered to be part-time service for purposes of computing benefits under chapters 83 and 84 of title 5.

"(e) REGULATIONS.—The Secretary shall prescribe regulations for the implementation of this section.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 of such title is amended by inserting after the item relating to section 7456 the following new item:

"7456a. Alternate work schedules.".

SEC. 4. APPOINTMENT OF NURSES WHO DO NOT HAVE BACCALAUREATE DEGREES.

Section 7403 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(h) In a case in which a registered nurse applying for an appointment under this chapter as a registered nurse has presented the qualifications established under subsection (a) for such an appointment, the lack of a baccalaureate degree in nursing shall not be a bar to appointment, and in such a case the registered nurse shall not be denied appointment on that basis.".

SEC. 5. TECHNICAL CORRECTION TO LISTING OF CERTAIN HYBRID POSITIONS IN VETERANS HEALTH ADMINISTRATION.

Section 7401(3) of title 38, United States Code, is amended—

(1) by striking "and dental technologists" and inserting "technologists, dental hygienists, dental assistants,"; and

(2) by striking "technicians, therapeutic radiologic technicians, and social workers" and inserting "technologists, therapeutic radiologic technologists, social workers, blind rehabilitation specialists, and blind rehabilitation outpatient specialists".

○

I

108TH CONGRESS
2D SESSION

H. R. 3849

To amend title 38, United States Code, to provide permanent authority for the Secretary of Veterans Affairs to continue to operate a program to provide counseling and treatment for veterans who while in military service experienced sexual trauma or sexual harassment.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 26, 2004

Mr. RODRIGUEZ (for himself, Mr. EVANS, and Mr. GUTIERREZ) introduced the following bill; which was referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to provide permanent authority for the Secretary of Veterans Affairs to continue to operate a program to provide counseling and treatment for veterans who while in military service experienced sexual trauma or sexual harassment.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Military Sexual Trama Counseling Act of 2004".

SEC. 2. PERMANENT AUTHORITY FOR SECRETARY OF VETERANS AFFAIRS TO OPERATE SEXUAL TRAUMA COUNSELING PROGRAM.

Section 1720D(a) of title 38, United States Code, is amended—

(1) in paragraph (1), by striking "During the period through December 31, 2004, the" and inserting "The"; and

(2) in paragraph (2), by striking ", during the period through December 31, 2004,".

○

I

108TH CONGRESS
2D SESSION

H. R. 4248

To amend title 38, United States Code, to extend the authority of the Secretary of Veterans Affairs to make grants to expand or modify existing comprehensive service programs for homeless veterans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 29 2004

Mr SMITH of New Jersey (for himself and Mr EVANS) introduced the following bill; which was referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to extend the authority of the Secretary of Veterans Affairs to make grants to expand or modify existing comprehensive service programs for homeless veterans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Homeless Veterans Assistance Reauthorization Act of 2004"

SEC. 2. EXTENSION OF AUTHORITY FOR SECRETARY OF VETERANS AFFAIRS TO MAKE GRANTS FOR ASSISTANCE TO HOMELESS VETERANS.

Section 2011(a)(2) of title 38, United States Code, is amended by striking "September 30, 2005" and inserting "September 30, 2008"

SEC. 3. AUTHORIZATION OF APPROPRIATIONS.

Section 2013 of title 38, United States Code, is amended—

(1) in paragraph (4), by striking "$75,000,000" and inserting "$100,000,000", and

(2) by adding at the end the following new paragraphs:

"(5) $100,000,000 for fiscal year 2006

"(6) $100,000,000 for fiscal year 2007

"(7) $100,000,000 for fiscal year 2008 "

○

DRAFT

(Original Signature of Member)

108TH CONGRESS
2D SESSION

H. R. _____

To amend title 38, United States Code, to reform the qualifications, selection, and nomination requirements for the position of Under Secretary for Health of the Department of Veterans Affairs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. SIMMONS introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title 38, United States Code, to reform the qualifications, selection, and nomination requirements for the position of Under Secretary for Health of the Department of Veterans Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. APPOINTMENT OF UNDER SECRETARY FOR HEALTH OF DEPARTMENT OF VETERANS AFFAIRS.

Section 305 of title 38, United States Code, is amended—

(1) by striking paragraph (2) of subsection (a) and inserting the following:

"(2) The President shall nominate a candidate for Under Secretary for Health—

"(A) on the basis of a candidate's demonstrated executive knowledge, skill and ability in health care administration, health policy formulation, and health care financial management; and

"(B) on the basis of a candidate's record of experience in executing health care programs of the Department or programs of similar scope in the public or private sectors."; and

(2) by striking subsections (c) and (d) and inserting the following:

"(c) Whenever the President removes the individual who occupies the position of the Under Secretary for Health, the President shall communicate the reasons for that action to Congress.

"(d)(1) Whenever a vacancy in the position of Under Secretary for Health occurs or is anticipated, the Sec-

retary shall recommend an individual to the President for nomination to the position as soon as practicable.

"(2) Before making a recommendation under this subsection, the Secretary shall establish a search for candidates for that recommendation and, in connection therewith, shall consult with the following persons:

"(A) Persons representing clinical care, medical research, and health education activities affected by the Veterans Health Administration, including persons representing medical and health science colleges and universities affiliated with facilities of the Department in training and educating health care practitioners and conducting medical research.

"(B) Persons representing veterans served by the Veterans Health Administration, including veterans service organizations recognized under section 5902 of this title.

"(C) Persons who have experiences in the executive management of health care, education, and medical research programs of similar scope to those of the Department in the public or private sectors.

"(D) The chairman and members of the Special Medical Advisory Group established under section 7312 of this title.

Opening Statement
Honorable Rob Simmons
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
May 6, 2004

I welcome fellow Members, distinguished witnesses and others in attendance. I especially want to welcome Gordon Mansfield, my friend and newly confirmed Deputy Secretary of Veterans' Affairs, to his first appearance before this Subcommittee.

This is a legislative hearing. We have five bills before the Subcommittee today. They are H.R. 4020, the State Veterans Home Nurse Recruitment Act of 2004; H.R. 4231, Department of Veterans Affairs Nurse Recruitment and Retention Act of 2004; H.R. 3849, Military Sexual Trauma Counseling Act of 2004; H.R. 4248, Homeless Veterans Assistance Reauthorization Act of 2004; and a draft bill that I am considering introducing based on the testimony we hear today that would reform the qualifications and selection requirements for the currently vacant position of the Under Secretary for Health.

The State Veterans Home Nurse Recruitment Act, introduced by Chairman Smith and Mr. Evans, would direct VA to make

payments to states for assisting State veterans' homes in hiring nurses to care for veterans. State homes that currently receive per diem payments from VA and have established employee incentive programs would be eligible to apply for incentive assistance and could receive up to 50 percent of the annual cost of such a program.

The second bill, H.R. 4231, a bill I introduced, would authorize several new and innovative initiatives to help VA attract and retain nurses. Today is National Nurses Day, so it is very appropriate that our Subcommittee is examining bills that could affect the 35,000 nurses who work in the Department of Veterans Affairs. My bill would establish a pilot program for VA to use outside recruitment agencies, and interactive and online technologies, to improve its recruitment of nursing personnel. It also would allow VA to offer three new alternative work schedules for nurses. My bill would prohibit VA from denying employment to a registered nurse because the nurse lacks a baccalaureate degree. Finally, the bill would incorporate blind rehabilitation specialists into certain health care positions that the VA is permitted to appoint through the use of a so-called "hybrid Title 38" direct appointment authority. Congress, in Public Law 108-170, expanded the categories of VA direct health care staff who

may be appointed with this novel authority. We believe that VA's recruitment and retention of this additional relatively small number of key clinical staff in blind rehabilitation could be aided by adding them to the hybrid category. The bill also would provide a technical amendment to the language authorizing hybrid-category positions.

H. R. 3849, the Military Sexual Trauma Act of 2004, is legislation our Ranking Member, Mr. Rodriguez introduced. This bill would make permanent the current authority of the Secretary to provide sexual trauma counseling to veterans. I strongly support this bill.

H.R. 4248, the Homeless Veterans Assistance Reauthorization Act of 2004, is a bill Chairman Smith introduced to extend the authority of the Secretary to continue making grants to provide programs for homeless veterans. The Administration's Fiscal Year 2005 budget proposal calls for an increase in the grant and per diem program spending limit from $75 million to $100 million. This bill would authorize that spending increase along with extending VA's basic authority to conduct these programs for homeless veterans through 2008.

Finally, we will consider a bill to reform the qualifications and selection requirements for the position of the Under Secretary for Health. For ten years or more the matter of identifying candidates for this key position has been a concern. Current law requires a candidate to be a doctor of medicine; it gives a confirmed Under Secretary a four-year term of office; and it requires the Secretary to appoint a formal search commission, chaired by the Deputy Secretary and consisting of a specified number of members from various organizations and interests affected by VA health care, to identify and recommend no fewer than three candidates. These three candidates must be advanced to the White House, with or without the Secretary's recommendation for a particular selection. The President must either choose from this list the preferred nominee or return the list to the VA for additional searching. Eventually, a nominee emerges from a process that can consume 18 months or more, during which time the Veterans Health Administration is without permanent executive leadership. My draft bill would simplify these requirements while still maintaining basic elements of the search to ensure a careful and balanced vetting process occurs. I look forward to receiving testimony on this bill and all these bills.

Representing the Department of Veterans Affairs, in our first panel, is the Honorable Gordon Mansfield, the Deputy Secretary of Veterans Affairs, accompanied by the VA General Counsel, the Honorable Tim S. McClain; Dr. Jonathan B. Perlin, Acting Under Secretary for Health; and Mr. Thomas J. Hogan, Acting Deputy Assistant Secretary for Human Resources Management. Welcome to all. Mr. Secretary, we appreciate your appearing today and I would like to thank the Deputy Secretary and your colleagues for the value of your testimony before the Subcommittee.

In our second panel, I welcome the Honorable Linda S. Schwarz, Commissioner, Connecticut Department of Veterans Affairs; Dr. Andrea Mengel , head of the Department of Nursing, Community College of Philadelphia, representing the American Association of Community Colleges; Ms. Marsha Four, RN, Chair, VA Advisory Committee on Women Veterans; and Mr. Robert Van Keuren, Chairman, VA Advisory Committee on Homeless Veterans.

These individuals have all been requested to present their views on specific bills of interest to them or their organizations.

Our third panel represents the national veterans' service organizations. Our witnesses are Ms. Cathleen Wiblemo, Deputy Director Health Care, Veterans Affairs and Rehabilitation The American Legion; Mr. Rick Weidman, Director, Government Relations, Vietnam Veterans of America; Mr. Richard Jones, National Legislative Director, AMVETS; Mr. Richard Fuller, National Legislative Director, Paralyzed Veterans of America; Mr. Dennis Cullinan, National Legislative Director, Veterans of Foreign Wars; and, Mr. Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans.

I want to thank all our witnesses, and our Subcommittee Members, for their assistance and attention to these important matters.

STATEMENT OF
THE HONORABLE GORDON H. MANSFIELD
DEPUTY SECRETARY OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

May 6, 2004

Good morning, Mr. Chairman and Members of the Subcommittee.

I am pleased to be here to present the Department's views on several bills and a draft bill, which pertain primarily to veteran's health care and related administrative matters.

H.R. 4231

This bill would help make VA more competitive in its ongoing efforts to recruit and retain registered nurses. I am especially pleased that the bill includes VA's proposal allowing enhanced flexibility in scheduling tours of duty for registered nurses. Mr. Chairman, in testimony last Fall before this Committee, we noted the projected increase in the number of aging veterans and increased enrollment in the VA healthcare system by veterans of all ages over the next several years and the projected national shortage of registered nurses. VA's health care providers are its most important resource in delivering high-quality, compassionate care to our Nation's veterans. VA's nurses are critical front-line components of the VA health care team. We must be able to recruit and retain well-qualified nurses. The ability to offer compensation, employment benefits and working conditions comparable to those available in their community is

critical to our ability to recruit and retain nurses, particularly in highly competitive labor markets and for hard-to-fill specialty assignments. Thanks to the efforts of this Committee and the Senate Veterans' Affairs Committee, VA has been able to offer generally competitive pay for nurses in most markets. VA continuously monitors the recruitment and retention of health care providers, particularly nurses, monitoring trends in private sector employment and workforce projections.

VA generally supports H.R. 4231 as it will assist VA in meeting the increasing challenge of recruiting and retaining sufficient nurses to meet its patient care needs.

Section 3 of H.R. 4231 adopts a VA proposal for enhanced flexibility in scheduling tours of duty for registered nurses. VA strongly supports this provision. This provision will help VA remain a competitive place of employment for nurses and to meet current and future veteran healthcare needs.

Your bill would also establish a pilot program to study innovative recruitment tools to address nursing shortages at VA health-care facilities, to be carried out in a region adversely affected by a nursing shortage. Using the services of a contractor, VA would identify and implement proven private sector recruitment practices. Such practices would include employer branding and interactive advertising strategies; internet technologies and automated staffing systems; and the use of recruitment, advertising and communication agencies. In carrying out the pilot program, the bill would require VA to streamline hiring procedures. If necessary, VA would be required to submit proposed legislation. Within one year, VA is to report to the House and Senate Veterans' Affairs committees on the pilot program. VA is already undertaking numerous initiatives to improve nurse recruitment and retention. Some of the aspects of the bill appear duplicative of these initiatives. Therefore, we believe this proposal is unnecessary.

H.R. 4231 also would amend section 7403 of title 38 to provide that a registered nurse who applies for appointment and who meets VA's qualification standards may not be denied appointment based on the fact that such nurse does not have a baccalaureate degree. VA believes this proposal is unnecessary.

The lack of a baccalaureate degree is not a bar to appointment under VA's current qualification standards. We note that we have provided the Committee with information that VA currently employs and continues to appoint many nurses educated in diploma and associate degree programs. VA hires graduates of associate degree and diploma programs at the Nurse 1 grade, and graduates of associate degree and diploma programs with bachelor degrees in related fields are eligible for appointment and promotion to the Nurse II grade, the same grade as are nurses with a Bachelor of Science in Nursing (BSN). In addition, VHA provides financial support to nurses desiring to obtain a higher nursing degree. VA does not "deny" appointment based on the lack of a baccalaureate degree.

Finally, section 5 is a technical amendment to correct the titles of some of the new hybrid occupations, and adds additional occupations to those converted. Public Law number 108-170 converted a number of additional VHA health care positions to hybrid status. This section would substitute "dental hygienists" and "dental assistants" for "dental technologists", and would substitute "technologists" for "technicians" and therapeutic radiologic technologists" for therapeutic radiologic technicians". VA supports the clarification of the occupations converted to hybrid status. In addition, this section would convert blind rehabilitation specialists and blind rehabilitation outpatient specialists to hybrid status. VA is currently reviewing the need for additional hybrid positions and, therefore, cannot comment on this proposal at this time.

H.R. 4020

H.R. 4020 would add a new section to title 38, United States Code, to require VA to make payments to States to assist them in hiring and retaining nurses at State veterans homes. To receive these payments, a State would need to establish an employee incentive scholarship program or other a similar program designed to reduce nursing shortages at its State homes. The programs would also need to meet any criteria that VA prescribes by regulation. VA would contribute 50% of the actual cost of the State program, but limited to 2% of the total per diem payments that the State would receive for that home for any fiscal year. States would be required to submit reports to VA on their use of the funds and the effectiveness of their programs.

VA opposes this proposal. This bill would require VA to make these payments from the Medical Services appropriations account. We estimate this bill could cost about $8.2 million per year. These funds would be taken from medical care programs for veterans. VA already pays States a per diem for the care of each veteran. These payments are intended to help cover all the costs of operating State homes including those involved in nurse recruitment. In times of fiscal constraint, we do not believe this additional grant to state homes at the expense of VA's own medical programs can be justified.

Draft Bill re Qualifications and Selection of Under Secretary for Health

This draft bill would amend section 305 of title 38, which concerns the procedures for appointment and qualifications of the Under Secretary for Health. As currently written, section 305 requires that the Under Secretary be a physician. The proposal would delete that requirement and substitute in its stead a requirement that the Under Secretary have executive knowledge, skill and

ability. It would require that such knowledge, skill and ability be in health care administration, policy formulation and financial management. The draft bill also would eliminate the current four-year term for that position, and the current search commission process utilized to recommend candidates to the President for vacancies. Instead, the Secretary would be required to conduct a search for candidates and make a recommendation to the President. In conducting the search, the Secretary would be required to"consult" with stakeholders similar to those required to be on the search commission under the current procedure.

VA supports enactment of these amendments as an improvement over current law, but we believe that the best outcome would be to amend section 305 to provide simply that the Under Secretary is appointed by the President, by and with the advice and consent of the Senate, and that the Under Secretary shall supervise the Veterans Health Administration under the authority of the Secretary of Veterans Affairs. The VHA medical system is the largest in the world, with 158 hospitals, more than 850 ambulatory care and community-based outpatient clinics, 132 nursing homes, 42 domiciliaries, 73 comprehensive home-care programs, 21 service networks and 206 Vet (Readjustment Counseling) Centers. More than 4.8 million people received care in VA health care facilities in 2003, with nearly 600,000 inpatient admissions and approximately 49.8 million outpatient visits.

VHA also manages the largest medical education and health professions training program in the United States. VHA facilities are affiliated with 107 medical schools, 55 dental schools and more than 1,200 other schools across the country. Each year, about 81,000 health professionals are trained in VHA medical centers. More than half of the physicians practicing in the United States have had part of their professional education in the VA health care system.

VA's medical system additionally serves as a backup to the Department of Defense during national emergencies and as a federal support organization during major disasters.

Moreover, VHA has experienced unprecedented growth in the medical system workload over the past few years. The number of patients treated increased by nearly seven percent from 2002 to 2003.

Because of the complexity, size and scope of VHA's operations, the person who heads VHA first and foremost must be someone with significant executive leadership ability and a demonstrated track record. The President should not be limited to appointing a physician to this critical leadership position, but should be able to appoint the person with those executive qualifications that best meets the needs of VHA.

We also favor the proposal to replace the formalized Search Commission process with a less-formal search process. The Search Commission process has proven to be very cumbersome and very slow. Importantly, the less-formal search process would retain stakeholder's involvement on a consultative basis. This proposal would allow the President to fill a vacant Under Secretary position in a more expeditious manner, without sacrificing important stakeholder input.

Finally, we note that the Subcommittee has inserted as section 2 of the draft bill a technical amendment to section 8111(d)(2) of title 38 to clarify the purposes for which the DOD-VA Health Care Sharing Incentive Fund may be used. The amendment would add at the end "and shall be available for any purpose authorized by this section". We thank the Subcommittee for this and strongly concur with this provision.

H.R. 4248

H.R. 4248 would extend to September 30, 2008, VA's authority to carry out the Homeless Providers Grant and Per Diem Program. Currently, authority for the program will expire on September 30, 2005. It would also authorize $100

million in appropriations for each of fiscal years 2005, 2006, 2007, and 2008. Currently, $75 million is authorized for fiscal year 2005.

VA strongly supports H.R. 4248. VA's Homeless Providers Grant and Per Diem Program is a highly successful collaborative effort between VA and non-profit organizations and local and state government agencies to furnish needed outreach, supportive services, and transitional housing services to homeless veterans. Since the program was authorized in 1992, VA has obligated $76 million to the grant component of the program. These funds have resulted in the development of 6,400 transitional housing beds and 17 independent service centers and the purchase of 128 vans.

Similar success is found with the per diem component of the program. The most recent awards were used to support 1,583 beds in 80 programs. To date, under the per diem only program, 3,799 new beds are either operational or coming on-line.

Still, VA needs to continue working with its community partners to develop more transitional housing for homeless veterans across the country. VA estimates the cost associated with enactment of this proposal to be $8,956,672 above the currently authorized level for fiscal year 2005. We estimate that to ensure full funding for this program for fiscal years 2006, 2007, and 2008, we will require $91,698,224, $81,996,208, and $86,282,778, respectively. We therefore welcome the Committee's proposal to increase the level of authorized appropriations for this program.

H.R. 3849

H.R. 3849 would permanently authorize VA's program to provide counseling services and care for sexual trauma. Currently, VA's authority for this program extends only through December 31, 2004.

VA strongly supports making this treatment authority permanent. The number of women veterans seeking VA counseling and treatment for military sexual trauma continues to increase at a substantial rate. Likewise, the number of women who serve in the Armed Forces, the Reserves, and the National Guard continues to grow. VA must therefore be able to provide needed sexual trauma counseling and related health care to these current and future veterans without any lapse in program authority. Enactment of H.R. 3849 would achieve that goal. VA estimates there would be no additional costs associated with enactment of this proposal.

Mr. Chairman, we understand that the Committee will be working with the Senate Veterans' Affairs Committee concerning VA's proposed legislation to reform of VA's Physicians and Dentists pay authority. VA very much appreciates the Committee's interest in this very important subject. VA is in a critical situation with increasing needs of veterans for health care while our current pay system leaves us in a very non-competitive position for recruiting the physician and dentist staff we need today and into the future. The expense of contracting for necessary specialty care continues to increase.

We also request the committee to act on draft bills we forwarded to Congress that would provide for comparability pay for the Director of Nursing Programs, Nurse Executive Pay, and clarify the authority of the Secretary to promulgate regulations relating to title 38 employees' conditions of employment, and to clarify the exclusion from coverage under general civil service laws of title 38 personnel laws and regulations. All of these proposals are important to the Department and its ability to better serve America's veterans.

This concludes my prepared statement. I would be pleased to answer any questions you may have.

TESTIMONY

of

LINDA SPOONSTER SCHWARTZ RN, MSN, DrPH, FAAN

CONNECTICUT COMMISSIONER OF VETERANS' AFFAIRS

Before

HOUSE VETERANS AFFAIRS

SUBCOMMITTEE ON HEALTH

MAY 6, 2004

Good Morning Mr. Chairman, thank you for the opportunity to comment on HR 4020 State Veterans' Homes Nurse Recruitment and Retention of 2004 and HR 4231 The Department of Veterans Affairs Nurse Recruitment and Retention Act of 2004. I have also added my comments on HR 3849 Military Sexual Trauma Counseling Act of 2004.

Thank you for your interest in recruitment and retention of nursing personnel for services to America's veterans. The insights gained as a professional nurse and experiences in academic nursing programs have been very helpful in my new position as Connecticut Commissioner of Veterans' Affairs. Before addressing the particulars of the legislation suggesting the remedies for the shortage of nursing personal in veteran health care systems, it is important to acknowledge that this shortage is a symptom of a larger problem of the declining numbers of students entering the nursing field and the increased numbers of nurses eligible for retirement.

I believe this is the third "nursing shortage" I have encountered in my 38 years of nursing. Ten years ago, it was easy to predict that the bulk of the nursing population would "hit" retirement age in the early years of the 21st Century. Indeed, general shortages in most health professions have continued unabated for some time. The difficulties in recruitment and retention of nursing staff are not exclusive to the Veteran Health Care System. However as the largest health care system in the Nation, it is unwise to overlook the dynamics this drain on the nursing profession has on our discussion today. Nurses and care givers at the patient's side are the backbone of America's health care delivery systems system and a national resource that needs to be nurtured and enhanced. Problems associated with the increasing nursing crisis merit the attention of Congress and all providers of health care. The dynamics of the basic problem do influence the success any proposed legislative measures may suggest to help the US Department of Veterans Affairs and State Veteran Homes.

Recently, Dean Catherine Gilliss of Yale School of Nursing and member of the Leadership and Policy Work Group on the Future of Nursing in Connecticut identified the salient points of the situation. In CT, the shortage is estimated to be among the worst in the nation. By 2020, it is estimated that the demand for nurses will outstrip supply by 808,000 RNs

in our state. This ranks Connecticut as the fifth worst case scenario in the nation. The average age of CT's RN work force is 45 years, and few replacements are in the educational pipeline for the anticipated retirements. By 2020, the CT population will be older and there will be a significant shortage of nurses to care for the aging population.

The national shortage is the result of several intersecting causes:

1. Fewer entries into the profession of nursing
2. A significant shortage of faculty to prepare new nurses, even where applicant pools are increasing;
3. The absence of clinical sites for training new nurses
4. The loss of prepared nurses from the work force, secondary to the demands of the work environment (e.g., increased pt. acuity; shorter pt. stays; limited scope of work and focus on administrative rather than clinical work.
5. Lack of participation in clinical decision-making and institutional governance.

Contributing to the problem in Connecticut is the significant lack of qualified faculty. In our state, Deans and Educational Program Directors believe this is among the most important leverage points for solving the nursing crisis. The Deans and Directors have begun to develop job sharing for faculty and pooling the incoming expressions of interest in the many open faculty positions throughout the state's programs. In fact, they are exploring alternative approaches to preparing nurses to serve as faculty so that they can open their doors to additional students. Teacher preparation is a priority. That same group is now developing an education master plan for nursing that will take into consideration the work force demands and supply to plan the enrollments and resources needed for the educational programs. The Connecticut Nursing Career Center was initiated to guide those interested in nursing toward programs and a Connecticut Career Ladder Program is assisting those who are prepared at the entry levels in health careers (e.g., CNAs and LPNs) to accomplish educational articulations to advance their careers.

"Veterans Homes Nursing Care at the Crossroads"

Nearly 32,000 veterans rely on long term care provided by 128 state veterans' homes. VA considers the relationship between States and the federal program to be a "partnership", which in fact exists in the per diem payments and the State Veteran Home Construction program. For example the national average cost per diem for a State is $171.85, which is offset by a payment of $57.78 for nursing home and hospital care and $27.19 for domiciliary care. A case has been made that many veterans in State Homes would be eligible for full support (veterans with Service Connected Disabilities (SCD) rated 70 or greater or who require nursing home care for their SCD) should be reimbursed at the rate any other nursing home in the state would receive $170/day. VA General Counsel has ruled that because State Homes were constructed using VA dollars the greater rate of reimbursement does not apply. I would point out that Rocky Hill Veterans Home was not built with VA dollars. We are on the list for much needed assistance from the VA State Home Construction program. I believe the General Counsel ruling is pejorative to States, like Connecticut who took the initiative to serve veterans before the Home Construction program began.

Some of the same root causes of the national nursing shortage were also identified in the recent "Veterans Homes Nursing Care at the Crossroads" (2002-2003), which was a survey conducted by the Armed Forces Veterans Homes Foundation with support from the Kellogg Foundation. Namely the demands of the workplace with respect to the great burden of workload, acuity levels among residents, inadequate time to care for veterans, uncertain work schedule, lack of professional development opportunities, inadequate support and respect and low pay. Interestingly, benefits were cited as a positive feature in State Homes.

Just as all politics are local, there are variations in needs and solutions to the question of adequate nursing personnel to care for veterans. My first suggestion is that this is a "systems issue". You may know that the State of Connecticut Department of Veterans' Affairs is making a concerted effort to avoid duplicating the services and programs of VA Connecticut with the idea in mind that we could create a seamless continuum of care for the

veterans in our state. This "Partnership" extends from referrals of eligible veterans among the agencies and shared resources like transportation and Staff development opportunities.

HR 4020 offers relief in the form of grants to State Homes to effect incentives programs, including scholarships to reduce the nursing shortages. There are advantages to the implementation of such a program. At the same time, Hr 4231 suggests a "pilot program" to study innovative recruitment tools, including measures which would relieve pressures of the workplace and make VA Nursing more attractive with provisions to relieve the shortage by appointing nurses who do not have a Baccalaureate to positions in the VA.

I think it is important to say "headhunters" or professional recruiters are sometime not the answer. Career advancement and investment in educational opportunities are very attractive especially with the costs of preparing nurses in undergraduate and graduate programs. VA once attracted nurses by offering tuition assistance and a stipend as well as opportunities for part time work while attending school. In return nurses acquired an obligation to work for VA on a scale commensurate with the investment made in the educational support of the nurses. This program was attractive in recruiting and retaining nurses in the VA.

My response to the State Veteran Home is that it is hard to generalize the needs of each of these programs. I do, however, believe that the program seems hard to implement. It is important to say that Connecticut and other states have spent time studying the problems and are in the process of implementing changes. Not all states have given the problems this amount of consideration. I would suggest criteria for this program developed by both VA and State Veteran Homes to assure the best investment of time and funding.

HR 3849 Military Sexual Trauma Counseling Act of 2004
As you may remember, I served as Chairman of VA's Advisory Committee on Women Veterans. I have been asked to testify several times on this same issue and could not pass up this opportunity to stress the importance of making this program permanent. Unfortunately sexual trauma associated with military service is not going to go away. As long as we

have military members living and working in communities they are going to experience the same difficulties as any community. This program has been in place since the early 90's in VA and the training and start up costs were absorbed long ago. Putting this program up for "sunsetting", as long as it is being used, does not make sense. I urge the Committee to put an end to these pilgrimages and require VA to make it a permanent program for veterans.

SUMMARY

Most importantly, some of the measures needed to recruit and retain nurses in any system cannot be legislated or funded. Respect for the work of nurses in our State Homes and VA facilities must come from the top down and must be tracked. Adequate scheduling of overtime demands all pivot on adequate funding of the programs to begin with. State Homes relieve VA of having to construct new long term care beds. They are cost effective because operational costs are the burden of the State. Recently, increases in VA per diem were made. For veterans in the domiciliary programs it was and increased from $26.95 to $27.19 an increase of $0.24 What can you buy for $0.24 in America today? And, what message did this send us and our veterans?

One Dupont Circle, NW
Suite 410
Washington, DC 20036

www.aacc.nche.edu
[T] 202.728.0200
[F] 202.833.2467

Testimony of Andrea Mengel, PhD, RN

Director of Nursing
at
Community College of Philadelphia in Philadelphia, PA

For the American Association of Community Colleges

On H.R. 4231, the Department of Veterans' Affairs Nurse Retention Act of 2004

May 6, 2004 at 9:30 a.m.

Before the House Veterans' Affairs Subcommittee on Health

Good morning Mr. Chairman and members of the Subcommittee. I am Dr. Andrea Mengel, director of Nursing at the Community College of Philadelphia in Philadelphia, PA. Thank you for the opportunity to address the Subcommittee about nursing recruitment and retention at the Veterans' Health Administration (VHA) and to present recommendations for strengthening the VHA nursing workforce from the American Association of Community Colleges (AACC). AACC represents 1,173 community colleges, which enroll 10.4 million students—44 percent of all U.S. undergraduates. Community colleges are committed to educating quality nurses and to enhancing the capacity of nursing education programs to address the nursing shortage. Half of the nation's registered nurses (RNs) and 70 percent of its licensed practical nurses (LPNs) are educated in community colleges.

Mr. Chairman, for more than 50 years, community colleges have provided the nation with RNs who take and pass at the same rate as do RNs with bachelor's degrees the licensure exam that all nursing graduates must pass to practice nursing. Throughout the nation, RNs who earned their degrees at community colleges are sharing the same responsibilities as they practice alongside their counterparts from bachelor's degree programs. Mr. Chairman, an RN is an RN. A bachelor's degree in nursing does not educate or authorize RNs to provide additional care to patients. Not a single state in the nation requires RNs to obtain bachelor's degrees to practice or advance within their careers. The Health Resources and Services Administration (HRSA) reports that 62 percent of employed staff nurses, including 45 percent in nurse clinician positions, 42 percent in clinical nurse specialist positions, 52 percent in head nurse positions and 65 percent in nurse supervisor positions, received their nursing educational preparation through associate degree or diploma nursing programs.

Additionally, HRSA reports that 15.6% of AD graduates hold a previous associate, bachelor's or master's degree. Many AD students pursue nursing as a second career. Further, community college graduates represent a large percentage of nurses of color in the profession, and bring a breadth of experience and dedication to the field of nursing. Associate degree nursing programs allow students to move into the workplace more quickly and at a lower cost. According to the U.S. Dept. of Education, on average students pay $1,379 per year in tuition at public community colleges—the majority of two-year colleges—compared to $3,746 per year in tuition at public four-year institutions. Through the National Nurse Education Initiative, the VHA is spending an average of $11,000 to educate an RN to the bachelor's level. This same funding could educate 3.9 RNs in associate degree programs, thereby providing a workforce of very high quality relatively quickly.

Nationwide, health care providers and patients alike value the care provided by RNs educated in community colleges. Surveys of RN employers and of patients themselves have shown no preference for RNs educated in one type of program over another. Data from a recent AACC survey indicate that hospitals and other facilities across the country are collaborating with most community colleges to enable them to expand enrollments in and increase graduations from nursing programs. These health care providers regard RNs receiving their education in associate degree programs so highly that most require those students to agree to serve at their facilities upon graduation in exchange for scholarships and many provide their own nurses—desperately needed to meet patient demands—to community colleges to enable the education of more RNs.

As a lifelong nursing educator, I am very disappointed in the hiring and promotion policy instituted nationwide by the Department of Veterans' Affairs. It is very disappointing that the VHA's hiring and salary progression policies do not value RNs practicing with the associate degree. The VHA's Nurse Qualification Standard is a disincentive to work at the VHA to 60 percent of new RNs as well as to hundreds of thousands of experienced RNs educated in associate degree programs. These RNs, who have achieved licensure exam passage rates equal to those of their bachelor's degree counterparts and have proven to provide quality patient care that cannot be differentiated from that provided by RNs with bachelor's degrees, cannot advance within the nursing profession at the VHA after years of experience as a registered nurse.

Nursing practice outside of the VHA is a better career choice for the well educated, quality, and often experienced nurses who earned their degrees at community colleges. With hundreds of choices of workplace opportunities, why would new RN graduates from associate degree programs choose to work at the VHA where the hiring and promotion policy will hold them back? Community colleges across the nation report that their graduates are not choosing the VHA. For example, not one of 300 RNs graduating from Community College of Philadelphia in the past four years chose a position at the VHA, and in 2002–

2003, Delgado Community College in New Orleans reported a graduation of approximately 400 RNs of whom not one chose the VHA as a workplace. Until 1994, Portland Community College placed many nursing students at the local VA hospital for clinical experiences, but ceased to do so because of the initiation of educationally discriminating hiring practices. AACC believes that for almost a decade Portland Community College graduates have not sought employment at local VA hospitals because of this policy change. The VHA is losing an invaluable opportunity to recruit nurses from Community College of Philadelphia and over 700 additional community colleges as well as from hundreds of facilities that value community college graduates. Why should experienced RNs leave environments where they are appreciated and rewarded to work in a system that discriminates against them? These RNs—new and experienced—are excellent, dedicated professionals who wish to provide patient-side care as well as to advance in their careers.

Mr. Chairman, AACC and the Community College of Philadelphia support higher and continuing education opportunities for all nurses in an inclusive model that promotes articulation of the nursing student at all levels. We know that the majority of RNs earn associate degrees. In addition, we know that:

- The NCLEX-RN examination pass rate for RNs with associate degrees in nursing is equal to the pass rate for RNs with bachelor's degrees in nursing.
- The number of minority students receiving associate degrees in nursing is increasing.
- Community colleges educate the majority of nurses practicing in rural and long-term care settings.
- RNs educated by community colleges are more likely to stay in their communities to practice nursing.
- Community colleges offer the most cost effective, efficient, and accessible nursing education programs.
- RNs with associate degrees represent more than one quarter of students enrolled in bachelor's nursing programs.
- The VHA's current policies are based on the unvalidated premise that more formal education automatically equates to better performance.

To continue to provide high quality nursing care for patients, AACC recommends that the VHA adopt the following hiring and promotion strategies:

- Employ all new RNs entering nursing at the same level.
- Provide promotion opportunities for all RNs based on performance and continuing education in specialty and master's degree programs.
- Support continuing education for all RNs.
- Encourage experienced RNs to work for the VHA.
- Utilizing the National Nurse Education Initiative funding, implement a RN to MSN program to address the nursing faculty shortage. (Expand

enrollments of RNs with associate degrees in the nation's more than 150 graduate nursing programs that enroll RNs without requiring bachelor's degrees in nursing.)

- Create and fund a program to provide opportunities for RNs planning to retire from the VHA to enroll in master's degree programs that will enable them to serve as faculty. (A shortage of faculty is preventing nursing programs from expanding enrollments to meet the nation's need for nurses.)

Mr. Chairman, the threats to the stability of our nation's health care system and the safety of patients posed by the nursing shortage are reported almost daily. Community colleges echo these concerns as nationwide hospitals, long-term care facilities, and others care for our sick, elderly, and disabled with inadequate numbers of nurses. Federal projections indicate a worsening nursing shortage. The Bureau of Labor Statistics projects a need for 1.1 million new and replacement RNs by 2012 and an additional 1.2 million nursing aides, home health aides, and similar health care workers between 2000-2010. A recent HRSA report on workforce trends predicts the percentage of time spent treating elderly and minority patients will increase significantly in coming years.

Mr. Chairman, the nation's health care system recognizes the value of RNs with associate degrees and employs and promotes them along side their bachelor's degree counterparts. AACC encourages the VHA to do the same. RNs from associate degree programs would welcome the opportunity to care to for our veterans.

Thank you for the opportunity to speak to you today. I welcome any questions.

STATEMENT

OF

MARSHA TANSEY FOUR, RN
CHAIR, ADVISORY COMMITTEE ON WOMEN VETERANS
U. S. DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

U. S. HOUSE OF REPRESENTATIVES
VETERAN AFFAIRS COMMITTEE

SUBCOMMITTEE ON HEALTH

REGARDING

H.R. 3849
MILITARY SEXUAL TRAUMA COUNSELING ACT OF 2004

MAY 6, 2004

Good morning Mr. Chairman and members of the Subcommittee. Thank you for the invitation and opportunity to address HR 3849, Military Sexual Trauma Counseling Act of 2004. I am Marsha Four, and I testify today as Chair of the Department of Veterans Affairs (VA) Advisory Committee on Women Veterans I served in the United States Army Nurse Corps with duty in Vietnam between 1969 and 1970 at the 18th Surgical Hospital, and I am presently employed as the Program Director for Homeless Veterans Services with The Philadelphia Veterans Multi-Service & Education Center, a non-profit agency, serving veterans in Southeastern Pennsylvania and am serving as a Director on the National Board of Directors of Vietnam Veterans of America.

Today I am here to talk about H.R. 3849, which would permanently authorize VA's program to provide counseling services and care for sexual trauma. Currently, VA's authority for this program extends only through December 31, 2004.

This is a particularly vital treatment authority for VA. VA has been aware of sexual abuse among women veterans since at least 1991 when Dr. Jessica Wolfe, then at the VA's Center for Post Traumatic Stress Disorder (PTSD), found that 8% of the women Gulf War veterans who participated in her survey reported an attempted or completed sexual assault during deployment. In response, the Senate Veterans Affairs Committee held hearings in 1992 that resulted in the

passage of Public Law 102-585, which authorized VA to provide counseling services to women veterans to "overcome psychological problems which, in the judgment of mental health professionals employed by the VA, resulted fom physical assault or sexual harassment that occurred while a veteran was serving on active duty." As you know, Congress subsequently amended the treatment authority in 1994 to authorize VA to provide necessary related care and to make the treatment authority gender-neutral.

INCIDENCE of SEXUAL TRAUMA

Between March and October 2002, VA screened 1,761,591 veterans for military sexual trauma. We found that one in 20 women veterans reported experiencing military sexual trauma. It is important to note that one in 100 men who were screened also reported that they had also experienced military sexual trauma. Given the demographics of the Armed Forces, this means that about half of those reporting military sexual trauma are men.

IMPLICATIONS

It has been shown that military sexual trauma may result in mental health problems and in some cases may also produce physical/medical problems Moreover, for some veterans, the experience of such trauma may contribute to

their risk of becoming homeless. Indeed, the Northeast Program Evaluation Center (NEPEC) reports that, out of a cohort of 443 homeless women veterans in the VA homeless women veterans pilot program, 38 percent reported they had been sexually harassed in the military and 43 percent reported they had been raped while on active duty.

VA's RESPONSE

VA has been very responsive to meeting the needs of veterans who have sought VA care and counseling for their sexual trauma. As you are aware, Military Sexual Trauma Counselors and Coordinators are in place throughout the system. Further, the system-wide screening process is well-established. In addition, educational programs have been designed to train primary care providers and practitioners as to the prevalence of, screening for, and treatment of the effects of military sexual trauma.

Assisting with the development, outreach, and advocacy of these initiatives and programs are the Women's Health Program Office, the Women Veteran Program Managers, the Center for Women Veterans, and the Advisory Committee on Women Veterans. The bottom line is VA has established the necessary infrastructure needed to support the counseling and treatment of victims of military sexual trauma.

PROPOSED EXTENSION

When we consider the large number of veterans who have accessed the system for military sexual trauma, both men and women, it seems apparent the need for this treatment authority exists and will continue indefinitely.Therefore, the Advisory Committee supports not only a renewal of the authority but further advocates that it be made permanent. This legislation assures that there never be a question in the minds of the victims that treatment for this trauma is seen as only temporary.

It is also the Advisory Committee's goal that those who need care and treatment for military sexual trauma have timely access to VA treatment. By making this permanent, the message is sent (1) that the pain these veterans suffered, and continue to suffer, as a result of their military sexual trauma is recognized and validated, and (2) that access to treatment will be available under this special treatment authority regardless of the veteran's eligibility for VA's general medical benefits package or enrollment priority category.

Thank you for providing me the opportunity to participate in these hearings. Mr. Chairman, this concludes my testimony.

STATEMENT OF
CATHLEEN WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS'
UNITED STATES HOUSE OF REPRESENTATIVES
ON
HR 4020, THE STATE VETERANS' HOMES NURSING RECRUITMENT AND RETENTION ACT OF 2004; HR 4231, THE DEPARTMENT OF VETERANS AFFAIRS NURSE RECRUITMENT AND RETENTION ACT OF 2004; HR 3849, THE MILITARY SEXUAL TRAUMA COUNSELING ACT OF 2004; HR 4248, THE HOMELESS VETERANS ASSISTANCE REAUTHORIZATION ACT OF 2004; AND A BILL (MR. SIMMONS) TO REFORM THE QUALIFICATIONS AND SELECTION CRITERIA FOR THE POSTION OF UNDERSECRETARY FOR HEALTH

MAY 6, 2004

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's view on the several pieces of legislation being considered by the Subcommittee today. The American Legion commends the Subcommittee for holding a hearing to discuss these important and timely issues.

HR 4020, "The State Veterans' Homes Nursing Recruitment and Retention Act of 2004"

This bill provides an incentive for nurses to be hired on or remain as employees of State Veterans Homes (SVHs) by providing payments to SVHs that offer an employee incentive scholarship or other incentive programs designed to promote hiring and retention of nursing staff. The payments to SVHs would cover up to 50% of the cost for each nurse employee up to 2% of the per diem payments received by the SVH in a fiscal year. In cases where a nurse employee refunded the incentive to the SVH for non-completion or other "breech" of the program requirements, the SVH would be allowed to retain the funds in its incentive program account as non-Federal funding. The incentives would be funded from existing SVH Per Diem accounts.

The American Legion applauds the intent of this bill to create incentives for qualified nurses to work with the residents of our State Veterans Homes. This bill, however, will create yet another unfunded mandate for the Veterans Health Administration (VHA) to absorb from its already inadequate budget. The American Legion believes that any new program or benefit should be accompanied by adequate appropriations to pay for it.

HR 4231, "The Department of Veterans Affairs' Nurse Recruitment and Retention Act of 2004"

Section 2 creates a one-year pilot program in a Veterans Integrated Service Network (VISN) that is currently experiencing the adverse effects of the ongoing nursing shortage. The project would assess the effectiveness of innovative human-capital tools and techniques in hiring and retaining nurses in VA healthcare facilities through the use of proven private sector techniques, including employer branding, interactive advertising, automated staffing systems and the use of recruitment, advertising and communications agencies. Section 2 would further streamline the hiring process by revising procedures and systems for selecting and hiring qualified nurses. Where enabling legislation is required to carry out this mandate, VA is to submit proposals to the Committees on Veterans Affairs of both chambers.

VA should take advantage of all opportunities to deal with its current shortage of nurses. The American Legion favors this pilot program that will utilize state-of the-art recruitment and advertising technologies.

Section 3 establishes a variety of new alternative work schedules to attract qualified nurses to work for VA. Flexible work schedules have long been used by the private healthcare sector to attract nursing personnel. This legislation will not only attract nurses who would have opted for other positions because of scheduling issues, but will provide Medical Center directors needed flexibility in staffing. The American Legion does not oppose this provision.

Section 4 amends Title 38, United States Code to prohibit VA from barring appointment of registered nurses (RNs) who do not have Bachelor's degrees. We note that the current language of 38 U.S.C. § 7403(g)(1)(A) does not currently require a baccalaureate degree, but " a recognized degree or certificate from an accredited institution in a healthcare profession...." This language allows VA to hire RNs who have Associates degrees in nursing from many of this nation's fine community college and other nursing schools.

This legislation appears intended to obviate a VA policy plan to hire only baccalaureate level RNs by October 2005. The American Legion understands the desire of VHA to upgrade its professional nursing staff; however, the plan would prove counterproductive and would reduce the pool of potential nurse-employees at a time when it is already disadvantaged by generally low salaries, high nurse-patient ratios and other factors contributing to VA's nursing shortage. The American Legion has no formal position on this issue, but believes that otherwise qualified RNs should not be precluded from VA employment for lack of a four-year college degree.

HR 3849, "The Military Sexual Trauma Counseling Act of 2004"

HR 3849 makes permanent the extension of authority for VA to provide military sexual counseling through 2004 under Pub. L. 106-177, The Veterans Millennium Health Care and Benefits Act. The American Legion supported the previous extension of this program established by Pub. L. 102-585, The Veterans Health Care Act of 1992 - Title I: Women Veterans Health Programs. This legislation authorized VA to treat veterans for military sexual trauma without a showing of service connection. It is estimated that a full 25 percent of female veterans and 2

percent of male veterans experience some sexual trauma while in the service, yet these incidents go largely unreported out of fear. The American Legion is pleased to support this measure.

HR 4248, "The Homeless Veterans Assistance Reauthorization Act of 2004"

HR 4248 extends the authority of VA to make grants to assist eligible entities in establishing programs to furnish, and expanding or modifying existing programs for furnishing outreach, rehabilitative services and vocational counseling and training to homeless veterans to September 2008. The amounts of appropriations authorized would increase in fiscal year 2004 from $75 million to $100 million and appropriate $100 million for each fiscal year through 2008.

The current administration vowed to end the scourge of homelessness within ten years. On any given night in this nation over 299,000 veterans are homeless. Less than 9 percent of our country's population served in the military and yet 34 percent of our nations' homeless are veterans and three-quarters of those are wartime veterans. $166 per homeless veteran per year for the next five fiscal years is not adequate support for intervention at the Federal level. The American Legion supports funding that will make a real impact on the problem of homeless veterans in this country.

Draft Legislation Regarding the qualifications and requirements of the Undersecretary of Health

The American Legion has some concerns regarding the changes in the appointment process outlined in this proposed legislation. The American Legion wants to ensure that the appointment process for the Undersecretary of Health is adequate in determining only the most highly qualified individuals are considered.

While The American Legion has no official position on this draft legislation, it is important that we fully understand the intentions of the changes that will take place as a result of this legislation.

Conclusion:

Mr. Chairman, The American Legion once again thanks you and the Subcommittee for its continued support of our veterans and looks forward to help improve and gain passage of legislation that addresses the health and quality of life for those who have served in our nation's Armed Forces.

The American Legion
For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★

May 6, 2004

Honorable Rob Simmons., Chairman
Subcommittee on Health
Committee on Veterans' Affairs
338 Cannon House Office Building
Washington, DC 20515

Dear Chairman Simmons:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the April 29 hearing concerning HR 4020, The State Veterans' Homes Nursing Recruitment and Retention Act of 2004; HR 4231, The Department of Veterans Affairs Nurse Recruitment and Retention Act of 2004; HR 3849, The Military Sexual Trauma Counseling Act of 2004; HR 4248, The Homeless Veterans Assistance Reauthorization Act of 2004; and a Bill (Mr. Simmons) to Reform the Qualifications and Selection Criteria for the Position of Undersecretary for Health.

Sincerely,

Cathleen Wiblemo, Deputy Director
Veterans Affairs And Rehabilitation

Vietnam Veterans of America

8605 Cameron Street, Suite 400 • Silver Spring, MD 20910 • Telephone (301) 585-4000
Main Fax (301) 585-0519 • Advocacy (301) 585-3180 • Communications (301) 585-5245 • Finance (301) 585-5542
World Wide Web: http://www.vva.org

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement

of

VIETNAM VETERANS OF AMERICA

Submitted

by

Richard F. Weidman
Director, Government Relations

Before the

United States House of Representatives
Committee on Veterans' Affairs
Subcommittee on Health

Regarding

Proposed Veterans Health Care Legislation

H.R. 4020, H.R. 4231, H.R. 3948, H.R. 4248

And

A draft bill to reform the qualifications and selection requirements for the position of the Under Secretary for Health

May 6, 2004

Mr. Chairman and other distinguished members of the subcommittee, on behalf of Vietnam Veterans of America (VVA) and our National President, Thomas H. Corey, we are pleased to have this opportunity to present our views with respect to several important pieces of veterans healthcare–related legislation pending before the Subcommittee today.

As an overall statement on several of the proposals to be considered here today, it must be noted that the nursing shortage is a national problem. This shortage is reminiscent of the so-called "worker shortage" of the early and mid 1990s when employers and the Department of Labor claimed that we had a shortage of qualified workers to fill all the jobs in America. This was a false shortage then and it is the same today. At that time there was no shortage of bright, intelligent hard-working people in America. Rather there was a shortage of bright, hardworking people who either were qualified or could easily be trained to be fully qualified who were willing to work for low wages and not so good benefits and/or status that was being offered. VVA believes that the same is true of nurses and the so-called "nurses shortage" today.

As you all are no doubt aware the Bureau of Labor Statistics (BLS) predicts that there will be 1.1 million more nursing jobs created in this decade, beyond those positions that exist today. As the average age of Americans grows older, more and more nurses, and clinicians of all types, and health care workers of all types will be needed to keep up with that growing demand. With the retirement of so many "baby boomers" and the lure of better pay and less pressure in other occupations, this need will be more acute. The genius of our economic system is that when the demand exceeds the supply of anything, the price will go up if the society truly values that good or service. When the price goes up, the supply will start to come back into balance with the demand. So it is with the labor market as well. The reality of overall nurses' pay, status, and working conditions, as well as the perception of same by those who might be interested in entering that profession, is the key to restoring balance.

H.R. 4020 State Veterans Home Nurse Recruitment Act of 2004

This proposal would amend the Federal veterans' benefits provisions to direct the Secretary of Veterans Affairs to make payments to States for assisting State veterans' homes in the hiring and retention of nurses and the reduction of nursing shortages at such homes. The proposed legislation also makes eligible for such assistance State homes that: (1) currently receive per diem payments from the Secretary for the care of veterans; and (2) have in effect an employee incentive scholarship or other program designed to promote the hiring and retention of nursing staff and reduce nursing shortages. The proposal limits such assistance to no more than 50 percent of the fiscal year costs of such a program.

The pending legislation also requires the assistance program to be implemented as expeditiously as possible, so that payments are made to eligible States commencing no

later than January 1, 2005. VVA does favor this modest program, as it will provide some assistance to the State Homes operated by the State in the recruitment and the professional development of vitally needed staff. The main problem with this proposal is that many states are in such difficult circumstances with their budget, that many may not be in a position to participate, even though they have the need.

H.R. 4231, the Department of Veterans Affairs Nurse Recruitment and Retention Act of 2004

This proposal provides for a pilot program in the Department of Veterans Affairs to improve recruitment and retention of nurses, and for other purposes. The flexibility envisioned by these provisions (and other possible such creative means) may prove to be useful to VA in some labor markets in meeting their base nursing needs. The idea of "streamlined hiring procedures" however, does trouble VVA, as this is usually code language for "getting around that pesky veterans' preference law." VVA will oppose any further diminishment of enforcing protection of the earned rights of veterans preference and disabled veterans preference in hiring and retention by the VA, especially given the less than good record of the Veterans Health Administration in this regard.

H.R. 3849 Military Sexual Trauma Counseling Act of 2004

Women have served our nation in every war since the American Revolution. In our war, most of the 7,500 women who served in-country were nurses who saw the detritus of war, the shattered bodies of young boys hardly grown to men, who experienced the horrors of war as profoundly as any grunt. They will always have our undying respect and gratitude.

Today, women comprise some 17 percent of our Armed Forces. And we must ensure that their special needs, particularly the emotional scars borne of sexual trauma, are met with understanding and compassion. Public Law 102-585, which was passed in 1992, authorized the VA to include outreach and counseling services for women veterans who experienced incidents of sexual trauma while on active duty. Public Law 103-452 amended that law to provide counseling for male veterans as well. However, the law fails to give the VA authority to provide sexual trauma counseling on a permanent basis: it is due to sunset at the end of this calendar year. To remedy this, VVA strongly supports H.R. 3849, the Military Sexual Trauma Counseling Act of 2004, introduced by Congressman Ciro D. Rodriguez, the Ranking Democratic Member of the House Veterans' Affairs Subcommittee on Health. This legislation would permanently extend the VA's authority to offer services to women and men who experienced sexual harassment, abuse or assault while serving on active-duty in the armed services. VVA requests that Congress enact this legislation making sexual trauma counseling a permanent facet of VA health care for men and women.

H.R. 4248 Homeless Veterans Assistance Reauthorization Act of 2004

In todays funding arenas, many municipalities utilizing federal dollars pursuant to the Stewart B. McKinney Act have placed an emphasis on permanent housing. Transitional housing dollars are literally inaccessible to non-profit agencies that provide services to homeless veterans, except through the VA. If chronic homelessness is to be ended, as stated by both the Secretary of Veterans Affairs and by the President, before the end of this decade, the Secretary's authority to make grants under Chapter 11, Section 2011 must be extended to September 30, 2008. By extending this authority, resources can be allocated to address the issue in a realistic timeframe. More funds must become available to the Secretary for this purpose. Similarly, chronic homelessness cannot be addressed without extensive outreach extending beyond September 30, 2005.

The Homeless Grant & Per Diem Program has enabled non-profit service providers the revenue needed to establish and maintain nearly 10,000 transitional residency beds nationwide. VA has invested many resources into these programs and attained great success. Through Grant & Per Diem dollars accessed by the non-profits, the non-profits availability to provide the services for homeless veterans in a transitional setting is much less expensive than VA residential care and the non-profits are able to provide a safe, stable, focused recovery environment for a longer period of time, thereby also increasing opportunities for the homeless veterans the opportunity to transition into the community with a steady job, dollars in the bank and resolution of both financial debts and debts to society.

VVA fully supports increasing the authorization allocation to $100,000,000 for fiscal year 2005 and extending and authorizing $100,000,000 for FY 06, 07 & 08 will enable the additional of homeless grant and per diem beds as so stated in H.R. 4248.

A draft bill to reform the qualifications and selection requirements for the position of the Under Secretary for Health

Vietnam Veterans of America does not favor this draft bill as written. VVA believes that the Undersecretary should always be a licensed medical clinician, including but not limited to Medical Doctor or advanced degree Nurses, and other similar clinical disciplines. The military model works well, and should be the model for the VA to follow in this regard. In the Army, the Medical Company Commander or the hospital Commander is always a clinician. This used to mean an M.D., but in recent years advanced degree nurses and nurse practitioners have been eligible for command slots as well. The Executive Officer (or Deputy) is almost always in the Medical Service Corps, and trained in logistics, finance, control of personnel, and all the myriad skills needed in order to successfully operate a medical facility or medical system.

VVA believes this model, used by both the Army and the Navy, is the one that can and should be adopted by the Congress for the Veterans Health Administration. In other words, the Undersecretary should be a clinician, and in the future the similar requirement for the Deputy Undersecretary should be removed in favor of strong administrative skills and experience.

As to changing the nature of the committee mandated by law from a selection committee to an advisory committee, VVA favors this change, as long as the final report of the proceedings of the Advisory Committee are transparent to the public at some point.

VVA strongly believes that the Secretary should be held fully accountable for performance, as should a President. Similarly, the Secretary should be able to choose his or her candidate(s) subject to the Senate confirmation process. VVA also favors elimination of the so-called 4-year contracts, and holding senior managers and clinicians fully accountable for their perf0ormance in every facet of their job. While executive pay and clinician pay should both be raised to be competitive in the marketplace, the ending of virtually automatic bonuses and cash awards to the "good old boys & girls club" that is to some degree still extant within the Veterans Health Administration must end.

CONCLUSION:

Vietnam Veterans of America sincerely appreciates the opportunity to present our views on these extremely important issues, and we look forward to working with you, Mr. Chairman, and your distinguished colleagues on this subcommittee to address and resolve these and other important matters of concern to our nation's veterans.

Vietnam Veterans of America

8605 Cameron Street, Suite 400 • Silver Spring, MD 20910 • Telephone (301) 585-4000
Main Fax (301) 585-0519 • Advocacy (301) 585-3180 • Communications (301) 585-5245 • Finance (301) 585-5542
World Wide Web: http://www.vva.org

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

VIETNAM VETERANS OF AMERICA
Funding Statement
May 6, 2004

A national organization, Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true for the previous two fiscal years.

For further information, contact:

Director of Government Relations
Vietnam Veterans of America
(301) 585-4000 ext 127

SERVING
WITH
PRIDE

A M V E T S

NATIONAL
HEADQUARTERS
4647 Forbes Boulevard
Lanham, Maryland
20706-4380
TELEPHONE 301-459-9600
FAX 301-459-7924
E-MAIL amvets@amvets.org

Testimony

of

Richard "Rick" Jones
AMVETS National Legislative Director

presented to the

Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives

on

1.) **H.R.4020, the State Veterans' Homes Nurse Recruitment and Retention Act;**
2.) **H.R.4231, the Department of Veterans Affairs Nurse Recruitment and Retention Act;**
3.) **H.R.3848, Military Sexual Trauma Counseling Act; and,**
4.) **H.R. 4238, Homeless Veterans Assistance Reauthorization Act.**

Thursday, May 6, 2004
9:30 am, Room 334
Cannon House Office Building

Chairman Simmons, Ranking Member Rodriguez, and Members of the Subcommittee:

On behalf of AMVETS National Commander S. John Sisler and the nationwide membership of AMVETS, I am pleased to offer our views to the Subcommittee on Health regarding the legislative matters at hand: H.R.4020, the State Veterans' Homes Nurse Recruitment and Retention Act; H.R.4231, the Department of Veterans Affairs Nurse Recruitment and Retention Act; H.R.3848, Military Sexual Trauma Counseling Act; and, H.R. 4238, Homeless Veterans Assistance Reauthorization Act. Thank you for this opportunity.

Mr. Chairman, AMVETS is a staunch advocate of providing veterans with appropriate benefits and services *earned* through honorable military service. As a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces, our organization continues its proud tradition, providing not only support for veterans and the active military in procuring their earned entitlements but also an array of community services that enhance the quality of life for this nation's citizens.

AMVETS applauds this Subcommittee and its effort to identify, examine and pursue legislative initiatives to implement solutions necessary for veterans to obtain the services, benefits and assistance they merit, earned and richly deserve.

H.R. 4020, the State Veterans' Homes Nurse Recruitment and Retention Act;

H.R. 4020, the State Veterans' Homes Nurse Recruitment and Retention Act, introduced by Chairman Chris Smith, would establish a program to enhance the employee incentive program used by States to recruit and retain quality-nursing staff. The program would allow States, on acceptance of application, to

enhance their veterans' home budgets by up to 50 percent of the annual cost of their current incentive program, but not greater than 2 percent of their overall per diem payments. The additional funds to State nursing homes would come from VA's health care budget.

For many senior veterans, the State veterans home is both first choice and last resort for those veterans no longer able to fight life's battles alone. In many cases, the home offers nearly everything from independent living to skilled nursing care.

We clearly recognize the growing need for long-term care. While the veterans population is projected to decline from 24.3 million to 20 million over the present decade, those aged 75 and older will increase from 4 million to 4.5 million and those over 85 will more than double, from about 640,000 currently to nearly 1.3 million in 2012.

AMVETS supports H.R. 4020 because it presents an enhanced pathway toward a Federal-State partnership that would improve the workplace of the State-run veterans nursing home. In supporting this legislation, AMVETS wishes the subcommittee to understand that we strongly support VA's effort to provide extended care services to enrolled veterans, and we will continue to support legislation that holds the potential to improve VA's response to the care needs of an aging veterans population.

Of course, the challenge ahead is for Congress and the administration to ensure VA is provided the necessary resources that improve delivery and enhance the measure of care for elderly veteran patients.

H.R. 4231, the Department of Veterans Affairs Nurse Recruitment and Retention Act;

H.R. 4231, introduced by Chairman Rob Simmons, seeks to authorize a set of new initiatives aimed to attract and retain nursing personnel at the Department of Veterans Affairs. First, the legislation would authorize the use of non-governmental recruitment teams, advertising agencies, and available internet resources to provide better tools and strategies for recruiting quality VA nurses. Second, the bill would direct VA to establish more flexible work arrangements aimed to accommodate nurses' work schedules and improve the attractiveness of VA's workplace for experienced nurses. Third, it would amend VA's current hiring policies that judge an applicant specifically on their educational background without giving full merit to a nurse's career experience in clinical competency and direct patient care. Finally, the bill makes technical corrections to permit direct appointment of blind rehabilitation specialists.

AMVETS agrees that VA needs to do all it can to recruit the nurses necessary to provide quality, timely care to America's veterans. As today's nurses retire, VA must be in a position to stave off nursing shortages. They must become more proactive and H.R. 4231 has the potential to help VA update and upbeat a more aggressive recruiting effort to reach the market place with more modern tools. AMVETS supports H.R. 4231.

H.R. 3848, Military Sexual Trauma Counseling Act;

H.R. 3848, introduced by Ranking Member Ciro Rodriguez, would permanently extend VA's authority to offer counseling services to women experiencing sexual trauma while serving in the Armed Forces. AMVETS clearly sees a need for making this program permanent. We agree that VA and the Federal government should give increased attention to the problem of sexual assault in the military.

In February, the Denver Post reported that dozens of women in combat zones were returning from deployment seeking sexual trauma counseling and reporting sexual abuse by fellow soldiers. While it is our understanding that officials at the Pentagon are finalizing a report to respond to the concerns on troops being sexually assaulted, victims of sexual trauma need present support and current treatment options. In this regard, we believe that the military could do a better job providing services for victims of sexual assault.

Given the fact, however, that VA already struggles with an inadequate budget, we recognize that providing the best possible health care to our Nation's veterans remains a difficult task. Without reinforcing and strengthening the VA healthcare system, VA will have to make difficult choices regarding the number of professionals whose work and lives assist those veterans in the sexual trauma programs. The legacy of the program and its potential to compassionately care for these veterans is at stake.

AMVETS supports H.R. 3848 and supports the provision of counseling support to veterans suffering from the ill affects of sexual trauma.

H.R. 4238, Homeless Veterans Assistance Reauthorization Act;

H.R. 4238, introduced by Chairman Chris Smith, would extend VA's grant making authority to provide assistance to programs for homeless veterans. Without this legislation the authority for this program would expire in September 2005. The bill also would increase the grant and per diem program-spending limit to $100 million from $75 million.

According to Department of Veterans Affairs estimates, more than a quarter-of-a-million veterans have no place to call home on any given night in America. Bringing homeless veterans in off the street and empowering them to become

productive individuals is a goal of AMVETS.

It is important to understand that we do not place the burden of helping our veterans solely on the federal government. AMVETS' departments and posts are engaged across the country in various programs aimed at helping homeless veterans and providing them with shelter, transportation, and help in combating their dependency on drugs and alcohol. Nevertheless, AMVETS clearly recognizes that authorizing and extending the Homeless Grant and Per Diem Program is critical in getting the job done. AMVETS strongly supports this bill.

Mr. Chairman, the membership of AMVETS knows that the members of this panel will do all they can to help veterans overcome homelessness. We applaud you for holding this hearing and thank the Subcommittee for extending us the opportunity to present our views on these legislative matters. We look forward to working you and other congressional champions to strengthen, enhance, and improve the earned benefits of our nations' veterans and their families.

###

SERVING
WITH
PRIDE

May 6, 2004

The Honorable Rob Simmons, Chairman
House Veterans' Affairs Committee
Subcommittee on Health
Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Simmons:

Neither AMVETS nor I have received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the May 6, 2004, hearing on issue before the Subcommittee

Sincerely,

Richard Jones
National Legislative Director

AMVETS

NATIONAL
HEADQUARTERS
4647 Forbes Boulevard
Lanham, Maryland
20706-4380
TELEPHONE 301-459-9600
FAX 301-459-7924
E-MAIL: amvets@amvets.org

STATEMENT OF

RICHARD B. FULLER

NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE

HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH

REGARDING

H.R. 4020, THE "STATE VETERANS' HOMES NURSE RECRUITMENT AND RETENTION ACT OF 2004"

H.R. 4231, THE "DEPARTMENT OF VETERANS AFFAIRS NURSE RECRUITMENT AND RETENTION ACT OF 2004"

H.R. 3949, THE "MILITARY SEXUAL TRAUMA COUNSELING ACT OF 2004"

H.R. 4248, THE "HOMELESS VETERANS ASSISTANCE REAUTHORIZATION ACT OF 2004"

DRAFT LEGISLATION TO REFORM THE QUALIFICATION AND SELECTION REQUIREMENT FOR THE POSITION OF THE UNDER SECRETARY FOR HEALTH

May 6, 2004

Mr. Chairman and members of the Subcommittee, on behalf of the members of Paralyzed Veterans of America (PVA) I am pleased to present our views on four introduced bills designed to improve a cross section of programs and designed to

improve the care and treatment provided our nation's veterans. I will also present our views on the draft legislation convening the position of the Department of Veterans Affairs Under Secretary for Health.

H.R.4020, the "State Veteran Home Nurse Recruitment Act of 2004"

The legislation would authorize the VA to provide grants to certain state veterans homes to assists these long term care facilities with incentives to promote the recruitment and retention of nurses. The payments could be no more than two percent of the total annual VA payment to a state for that state home. The state home must have an employee incentive scholarship program or other employee incentive program at a state home designed to promote hiring and retention of nursing staff. The VA payment cannot exceed 50 percent of the cost for each fiscal year of that employee incentive program.

The serious shortage of nurses in the United States is affecting all sectors of the health arena, both public and private. The private sector has adapted well in the competition for attracting nursing staff from a finite number of nurses in the profession by utilizing a wide variety of incentives to attract and retain staff. Extending education benefits is one of those tools. As the need for long term care grows in this country state veterans' nursing homes must increasingly compete with their counterparts in the private sector for nursing staff interested in working in the long term care sector.

This legislation allows a state home with an employee scholarship program or other such incentive program to receive up to two percent of its federal subsidy to apply up to 50 percent of the cost of the incentive program. True to the cost effective nature of the state veteran home program with its state/federal cost sharing function, the state would cover the payment for the balance of the recruitment and retention benefit.

PVA believes this program can have a definite benefit for a state home that has an employee incentive program and wishes to expend part of its annual VA allotment in this way.

H.R. 4231, the "Department of Veterans Affairs Nurse Recruitment and Retention Act of 2004"

The legislation would establish a pilot program to study innovative recruitment tools to address nursing shortages at Department of Veterans Affairs Health Care Facilities. The pilot program would allow VA to establish a variety of recruitment strategies to compete for nursing staff with other health care providers. These include advertising strategies, innovations in pay structure and working hour flexibility. It would also broaden the pool from which VA could attract nursing staff by dropping the requirement that all registered nurses have baccalaureate degrees.

For the same reasons cited above regarding the state veterans homes' ability to recruit and retain nursing staff, the VA, too, can be at a disadvantage in not having the same flexibility enjoyed by the private sector. In many ways the VA cannot advertise, and, even if it did, does not have the ability to react to changing employment marketing factors or provide incentives similar to those recruiting devices used by private sector facilities. The pilot program would give VA many of those tools, and, at the same time, assess the benefit and usefulness of a wider variety of incentives.

PVA supports this legislation, but we do offer a note of caution on the provision in section 4 which would lift the bar on appointing registered nurses who do not have baccalaureate degrees. The VA nurse is on the front line of veteran health care delivery, at the bed side. Certainly we would have no objection for VA to hire any licensed and fully qualified registered nurse as long as the hiring entity has the ability to fully judge and monitor the quality of the nursing services those individuals provide. Our main experience is with the care provided in spinal cord injury centers, a highly specialized, intensive, and multidisciplinary form of medical care. As with health care providers in other specialized services in the VA health care system, the spinal cord injury nurse must have very specialized skills and advanced training to provide a wide array of services to a highly disabled patient population. We would hope that this legislation, if enacted, would provide certain additional safeguards, such as additional management

quality controls within the pilot program, to make certain that health care, particularly in the area of specialty nurses, is not compromised.

H.R. 3849, the "Military Sexual Trauma Counseling Act of 2004"

The legislation would make permanent the VA authority to provide counseling and treatment for veterans who experienced sexual trauma or sexual harassment while on active duty. PVA supports this initiative.

H.R. 4248, the "Homeless Veterans Assistance Reauthorization Act of 2004"

The legislation would extend through FY 2008 the authority of the VA to provide grants to expand or modify existing comprehensive service programs for homeless veterans. It would also raise the authorization of appropriations for the program from $75,000,000 to $100,000,000 each year.

Sadly, veterans continue to be a major percentage of all homeless Americans. The VA in its role to "care for him who shall have borne the battle" must continue to support the highly successful array of programs designed to provide health care, housing, counseling rehabilitation and other services to this population. PVA fully supports the legislation.

Draft Legislation to Change the Qualifications, Selection, and Nomination Requirements for the Position of VA Under Secretary for Health

The proposed legislation would make major changes to Section 305 of Title 38 United States Code altering who can be nominated as Under Secretary for Health, by what process they are selected, and for what term they shall serve.

First, the draft bill would remove the requirement that the candidate for Under Secretary be a physician. PVA has no argument with this change. Health care management in the United States has come a long way since this provision was enacted in the legislation that elevated VA to cabinet level status in the late 1980's. At that time, the drafters of the legislation felt that only a physician could maintain the VA's interest in the well-being of the veteran patient over the cold determinations of a non-physician bureaucratic administrator who would only look to the well-being of the VA "system" over the needs of veterans. Time and experience have proven this decision well-intentioned, but outdated, in view of what the Veterans Health Administration (VHA) has become, how it is managed, and what it's day to day administrative needs are. There is no reason why a qualified physician could not be chosen the next Under Secretary for Health. There is also no reason why any otherwise equally qualified nurse or other allied health care professional with the same administrative qualifications could not be selected for VHA's top job. The same is true for an individual with no medical training but advanced education and experience in medical administration. With

this job, we are looking for a chief executive officer. We are looking for excellence, not pedigree. PVA supports this provision which will give those selecting the next Under Secretary the broadest possible pool of candidates from which to choose.

There are two other provisions in the draft legislation making major changes to section 305 we oppose. One provision would eliminate the requirement that the Under Secretary serve for a specific four-year term and leave the individual's service term open ended. PVA believes that the four-year term requirement serves a very valuable function. Under current law, once the Under Secretary has served the four-year term, that individual, wishing to continue service, must be re-confirmed by the United States Senate. The advice and consent of the Senate Committee on Veterans' Affairs and the Senate as a whole provides additional oversight over the conduct of the Under Secretary. The reconfirmation also provides an opportunity for others with interests in the operation of the Veterans Health Administration and its chief administrative officer to have the ability to opt into this process too and re-visit the qualifications and track record of this individual. At any point in time prior to the end of the four-year term or after the reconfirmation, the Under Secretary always serves at the pleasure of the Secretary and the President. But just as initial confirmation at the beginning of the Under Secretary's term serves an outside objective oversight function, so does this four-year end-of-term look-back process let the office holder, and all

others, know that the position is beholden to more than just one Secretary and one White House.

For many of the same reasons we oppose the provision in the draft bill to downgrade the role of the appointment commission established in section 305 to only an "advisory" position. Under current law, once there is a vacancy in the Under Secretary position, the Secretary of Veterans Affairs is required to appoint a commission drawn from specific individuals and interest groups, including veterans' service organizations. The commission is called on to screen all candidates for the job, select three of the top candidates, forward those names through the Secretary to the White House where one will be chosen from that group.

We are as convinced today as those who created this process in the original legislation that the selection of the Under Secretary, because of that individual's direct role over the health and well-being of millions of veterans, must be as objective as possible. The individual must be chosen on the merits with not even a hint of political considerations. The commission was created as a buffer to isolate the political process from the selection process by allowing the commissioners to screen and actually select the core candidates. We have no qualms about the current Secretary's ability and sincerity in choosing, basically on his own, a candidate for submission to the White House who would certainly meet all the qualifications we could expect in an Under Secretary for Health. But

who knows what lies down the road in future Administrations and with future Secretary's of Veterans Affairs. An "advisory commission" as called for in the draft bill could be only window dressing with no counter balance at all in a future Secretary's choice, or the choice of some future White House seeking appointment purely by partisan objective or potential preconceived disinterest in the mission of the VA health care system. The Secretary has already appointed the commission to begin to fill the current vacancy of Under Secretary for Health. The commissioners are drawn from the ranks of a broad spectrum of individuals and groups whose only wishes are to see VA health care succeed. That they should continue to make the first cut in the selection process seems only appropriate now and in the future. We strongly urge the subcommittee not to support changing their role and this process.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program — $228,000 (estimated).

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program — $228,803.

Fiscal Year 2002

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program — $228,413.

VETERANS OF FOREIGN WARS

OF THE UNITED STATES

STATEMENT OF

DENNIS M. CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

HEALTH-CARE LEGISLATION

WASHINGTON, D.C. MAY 6, 2004

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to express our appreciation for being included in today's hearing.

One of VFW's Priority Goals aims to see that veterans everywhere receive timely access to high quality healthcare. Although the main crux of that goal centers on the appropriations process and the need for adequate funding for the Department of Veterans Affairs (VA), the bills under consideration today would also improve health care for veterans. We are pleased to support them.

We strongly support H.R. 3849, the ***Military Sexual Trauma Counseling Act***. This legislation would grant permanent authority for VA's sexual trauma treatment programs. Current authority for the program is set to expire at the end of the current year.

VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D.C. 20002-5799
AREA CODE 202-543-2239 ● FAX 202-543-6719

The sexual trauma program is one of VA's many successes. It compassionately cares for veterans who have suffered from the after-effects of this trauma. It provides them with a safe environment to help them understand what has happened and to help them deal with the complex and life-changing psychological effects of these traumas. This program provides the specialized kinds of medical treatment that VA excels at. The mental health services it provides give these men and women a measure of dignity as they recover.

Since its inception in 1992, the program has been extended several times due to expiring authorities, and it is again set to expire at the end of the year. VFW believes that this is a program that works well and serves many veterans. It should be extended permanently. We should acknowledge the good work VA is doing and the many lives this program has changed. This legislation would do just that.

VFW also supports H.R. 4020, the ***State Veterans Home Nurse Recruitment Act***. This bill would apportion part of the grants VA provides to state veterans' nursing homes for programs that have an "employee incentive scholarship program or other employee incentive program...designed to promote the hiring and retention of nursing staff and to reduce nursing shortages." The legislation limits the maximum amount of money VA can earmark for these programs and requires an annual report detailing how these funds would be used.

We believe that long-term care is part of VA's mission to provide the full continuum of care to this nation's veterans. State nursing homes have served an increasingly integral part in VA's attempt to fulfill this mandate. It is estimated that there will be over 1.3 million veterans over the age of 85 in the next decade, up from the current 870,000. As this population ages, their need for care will skyrocket. VA must be up to the challenge of providing care.

We believe that this legislation will play a helpful role in addressing these needs. It will increase these homes' ability to recruit and retain the staff they will need to combat current and projected shortfalls.

We are pleased to support similar legislation, H.R. 4231, the ***Department of Veterans Affairs Nurse Recruitment and Retention Act***. It differs from the previous bill in that this legislation focuses on increasing nursing staff at VA facilities. It would create a pilot program in a VISN that faces a shortage of qualified nurses. This program would require the use of private-sector recruitment practices to include the use of internet technologies and recruitment, advertising and communications agencies.

VFW believes that this would be a worthwhile pilot program and that it may provide answers to the shortage problem, which could then be used system-wide. If VA is able to find a reasonable program that increases the number of qualified nurses, our members are sure to benefit.

This legislation also includes a section that would provide several alternative work schedules for nurses. Again, we would support this in that it may improve the availability and quality of health care services VA can provide to our veterans.

VFW is pleased to offer our strong support for H.R. 4248, the ***Homeless Veterans Assistance Reauthorization Act***. This legislation builds off of 2001's Homeless Veterans Comprehensive Assistance Act, which was so strongly championed by this Committee. H.R. 4248 would increase and extend the amounts available for grants under the program to $100 million from fiscal year's 2005 through 2008.

As strongly as we applaud this Committee's actions, we must take exception with the actions of the Appropriations Committees and of the whole Congress with regards to this

important legislation. Although the money was authorized in 2001, the proper level of funding was never actually appropriated. This is a travesty.

Estimates are that there are nearly 300,000 homeless veterans asleep on the streets of this country each night. This truly is unconscionable. These men and women once proudly wore the uniform of this country and have now retreated out of our sight. None of us should accept this. We as veterans' advocates, but especially as a grateful nation, have an obligation to seek out these men and women and to provide them with the skills and specialized treatments they need to better themselves and to return them to productive society.

Many of these men and women are homeless through no fault of their own. They may be afflicted with mental illnesses or with substance abuse diseases. They can be treated and they can improve. They just need our help. That is precisely why we support this measure. With just a little help, we can restore a measure of dignity to those former service member's lives.

These men and women are silent veterans. We do not see them every day and they do not have a powerful voice as constituents. We must stand up for them and this entire Congress must do right by them.

The final bill under consideration is a draft bill, which would amend the qualifications for VA's Under Secretary for Health. This bill enjoys our strong support. Chiefly, this important legislative initiative would eliminate the requirement that the Under Secretary be a Medical Doctor. Additionally, it would eliminate the position's four-year term.

In the twelve years since the position was first created, VA's health care system has undergone dramatic changes. VA is now an outpatient driven health care system that has nearly 8 million enrolled veterans in over 5,000 different locations. This crucial position does not require specific medical knowledge so much as the ability to administer and oversee a complex medical operation spanning the entire country. While we would expect that the Under Secretary

would have some experience in a medical setting, his or her skills as an executive must be of primary concern. The size and scope of the VA Health Care system as well as the diversity of staff and locations require an exceptional manager possessing extraordinary skill and commitment.

It is paramount that there be no impediment to seeking out and then securing the services of such an individual as Under Secretary for Health. In this regard we would also urge that a search committee is established toward this end. Along with members of the medical, managerial and scientific communities, it must also be comprised of members of our Veterans Service Organizations.

We also believe that this draft bill's section providing for the elimination of the four-year term represents an important improvement and safeguard. This would give the Department the ability to appropriately react if the Under Secretary is not performing up to standards. Further, it reduces some of the complications that can arise if the Under Secretary need be removed from office for not properly or fully fulfilling his or her duty.

Mr. Chairman, we again thank you for the opportunity to testify today. Veterans' health care is of paramount concern to our organization. VFW knows that our nation's obligation to provide timely quality health care is a result of the gratitude this nation has for its former defenders. This Committee clearly does an excellent job of living up to that obligation.

I would be happy to answer any questions you or the members of this Subcommittee may have.

Thank you.

STATEMENT OF
ADRIAN M. ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
MAY 6, 2004

Mr. Chairman and Members of the Subcommittee:

On behalf of the more than 1.2 million members of the Disabled American Veterans (DAV) and its Auxiliary, I wish to express my appreciation for this opportunity to present the views of our organization on four pieces of legislation before the Subcommittee.

These legislations cover a range of issues important to veterans and their families. The DAV is an organization devoted to advancing the interests of service-connected disabled veterans, their dependents and survivors. For the past eight decades, the DAV has been devoted to one single purpose: building better lives for our nation's disabled veterans and their families.

H.R. 3849

The Military Sexual Trauma Counseling Act of 2004 would make permanent the authority of VA to provide sexual trauma counseling to veterans. The DAV is concerned about the availability of quality mental health services for women veterans, especially women veterans who have experienced sexual trauma during military service. Only 43 percent of VA Medical Centers (VAMCs) have one or more designated women's health providers in outpatient mental health clinics to accommodate women veterans' special needs.

In addition to the 149,000 women serving in the National Guard and Reserve, more than 212,000 women serve on active military duty and comprise nearly 15 percent of the active force. As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health care services.

Despite the decline of the overall veteran population, the female veteran population of the United States is projected to increase by 6% between 2002 and 2020, from 1.2 million to 1.3 million. Currently, women veterans comprise approximately 5 percent of all users of VA health care services, and within the next decade, this figure is expected to double. With increased numbers of women veterans seeking VA health care following military service, it is essential that VA be equipped to meet their specific health care needs.

The DAV believes VA is obligated to deliver health care services to women veterans equal to those provided to male veterans. At our most recent annual National Convention, DAV delegates adopted a resolution seeking enactment of legislation mandating the provision of health care services, inclusive of gender-specific services, by VA to eligible women veterans to the same

degree and extent that services are provided to eligible male veterans, inclusive of counseling and/or psychological services incident to sexual trauma. Accordingly, we support this legislation and urge the Subcommittee to report this bill for consideration by the full committee.

H.R. 4020, H.R. 4231

The State Veterans Home Nurse Recruitment Act of 2004, H.R. 4020, would assist states in the hiring and retention of nurses and the reduction of nursing shortages at state veterans' homes. This legislation would direct VA to make payments to State homes that receive per diem payments from VA for the care of veterans, and have an employee incentive scholarship or other program designed to promote the hiring and retention of nursing staff. The assistance to state homes is limited to no more than 50 percent of the fiscal year costs of such recruitment and retention programs, and requires the assistance program to be implemented so that payments are made commencing no later than January 1, 2005.

H.R. 4231 would establish a pilot program to determine the effectiveness of certain recruitment and retention practices of qualified nurses, and to revise hiring systems and procedures to reduce the length of time of the hiring process. This bill also requires a report of findings be submitted no later than one year after the date of enactment. In addition, VA would be able to provide alternative work schedules and, upon completion of a specified alternative work schedule, would allow overtime pay for additional hours of work above and beyond the alternative work schedule.

DAV believes that nurses are part of the basic framework and nucleus for the provision of health care services to veterans. However, VA staffing levels are frequently so marginal that any loss of staff can result in a critical staffing shortage, present significant clinical challenges, and can result in adverse medical care. While VA has the largest nursing workforce in the country, with more than 55,000 registered nurses, licensed practical nurses, and other nursing personnel, VA is facing serious challenges in providing consistently high quality care and maintaining their specialized services.

DAV does not have a resolution from our membership on these two measures; however, their purposes appear beneficial. We do not oppose favorable consideration of H.R. 4020, and H.R. 4231 by the Subcommittee.

H.R. 4248

DAV believes in making a difference in the lives of homeless veterans across this nation. One of our top priorities is to help break the cycle of poverty and isolation, and move homeless veterans from the streets to self-sufficiency.

Supported by DAV's Charitable Service Trust and Colorado Trust, the DAV Homeless Veterans Initiative helps homeless veterans make the transition from life on the streets to one of productivity and normalcy by promoting the development of supportive housing and services to assist homeless veterans become self-sufficient and productive members of society. Since 1989, DAV allocations for homeless projects total over $1 million, which includes grants allowing the

expansion of VA medical center services for homeless veterans who suffer mental illness and substance abuse.

VA's partnership with other homeless-service providers is directly affected by the Homeless Providers Grant and Per Diem Program. H.R. 4248, the Homeless Veterans Assistance Reauthorization Act of 2004, would extend for four years VA's authority to make grants to assist homeless veterans, and increases the annual appropriation from $75 billion to $100 billion. Accordingly, DAV supports the passage of this important legislation, which provides VA the necessary resources to combat homelessness.

Pending Draft Bill

This bill proposes to reform the qualifications, selection, and nomination requirements for the position of VA Under Secretary for Health. Specifically, it would eliminate among other things, the requirement establishing a commission to recommend individuals to the President for appointment.

DAV is concerned that the elimination of a commission is the elimination of a fundamental process. Replacing the debate among a selected group of individuals who are from various fields and interests relevant to VA, with periodic consultations is cause for serious concern. The formal process executed by a commission involves careful consideration, reflection, interaction, and discourse, which is necessary for well-rounded decision making, similar to the function of this Subcommittee.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions you may have.

DAV DISABLED AMERICAN VETERANS
Building Better Lives for America's Disabled Veterans

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

[illegible] • [illegible] AVENUE, S.W. • [illegible] D.C. 20024-2410 • [illegible] (202) 554-3501 • Fax (202) 554-358[illegible]

Questions for the Record
Honorable Rob Simmons, Chairman
Subcommittee on Health
Committee on Veterans' Affairs
May 7, 2003

Oversight Hearing on Homeless Assistance Programs in the Department of Veterans Affairs

1. Fifty-eight percent of the community-based programs that were awarded grants in FY 2000 under the Per Diem Program were denied renewal grants in FY 2002. P.L. 107-95 specifically gave VA the authority to award technical assistance grants to help eligible organizations apply for the VA programs. Did VA provide any technical grants to any organizations?

Answer: VA recently published revised program rules for the Grant and Per Diem Program on March 19, 2003. With the publication of these rules, VA now has implemented the authority to award technical assistance grants to non-profit organizations. Those organizations can provide grant writing and technical assistance training to other organizations interested in applying for VA grants and grants from other federal agencies, state and local governments or other organizations in order to develop programs for homeless veterans. VA announced the Notice of Funding Availability (NOFA) for this technical assistance grant on May 5, 2003. Applications were due by June 4, 2003. VA received nine applications and is currently reviewing them. It is expected that awards will be announced in July 2003.

While technical assistance has not yet been made available through the technical assistance grant program, VA staff of the national Grant and Per Diem Office are available to answer questions from applicants about VA's Grant and Per Diem Program. Since February 1, 2003, this office has conducted over 75 application reviews with former applicants who have requested this assistance. The hour-long review sessions focus on the strengths and weaknesses of each application and should be helpful if former applicants choose to apply for VA funds under future NOFAs.

2. The current grant application rating system seems not to take into consideration whether an organization has an existing partnership with the VA to serve homeless veterans. It seems sensible to me that organizations that have made a commitment to serving homeless veterans, should be given consideration to continue successful programs. Are there any plans to change the current rating system to add weight for a history of effective service to veterans under the grant program?

Answer: The program rules published March 19, 2003, set forth criteria rating and ranking grant applications. Currently, there are no plans to change or revise this rating system to add weight for a history of effective services to veterans under the grant program. We believe the system used to rate and rank applications provides several

opportunities for organizations to offer information on effective services to veterans that have been previously provided. The extent and quality of the information submitted by the applicant in the proposal regarding past effective services to veterans can positively impact the applicant's ranking. In the application, applicants are asked to provide information regarding the organization's:

- Ability, the extent to which the organization has experience in activities similar to those proposed in the application. These activities include engaging homeless veterans, assessing supportive services needed, monitoring and evaluating participants, evaluating the effectiveness of the program, and making improvements based on that evaluation.

- Coordination, the extent to which applicants demonstrate that they have coordinated with Federal, State, local, private, and other entities serving homeless persons in the planning and operation of the project.

Additionally, in the criteria for ranking, those organizations that can demonstrate commitments from other community-based groups to provide supportive services for the project are given point advantages.

We believe that through the criteria discussed above, applicants that have served veterans in the past or that have positive working relationships with VA medical centers and regional offices, have an opportunity to sufficiently demonstrate these aspects of the program in the proposal and improve the competitiveness of their applications.

It is important to note that 36 of the 53 programs (68 percent) awarded funds under the FY 2002 NOFA had an existing partnership with VA to serve homeless veterans. VA previously funded these programs as either original "Per Diem Only" recipients or contract residential treatment programs under the Health Care for Homeless Veterans (HCHV) Program. These newly funded programs operate 1,060 of the 1,378 beds (77%) funded under the FY 2002 NOFA.

3. The Department testified in January that $10 million would be obligated for dental care for homeless veterans in FY 2003. Approximately how much has been allocated to date to provide dental services for homeless veterans? How many homeless veterans have been provided dental care under this program?

Answer: VA estimated that it would cost approximately $10 million to provide dental care to homeless veterans. VHA has issued Directive 2002-080, "Eligibility Guidelines for One-Time Course of Treatment for Certain Homeless and Other Enrolled Veterans," which outlines requirements for the provision of dental care for homeless veterans as specified in P.L. 107-95. Dental care will be provided from within existing resources. Information is not yet available on the number of homeless veterans who have received dental care as a result of this authority. At the end of FY 2003, VA's Northeast Program Evaluation Center (NEPEC) will conduct a retrospective review of the number of eligible

homeless veterans who received dental care in FY 2003, the type of dental care received, and the cost of such care.

4. Substance abuse/mental health treatment services and long-term case management are critical to helping homeless veterans make progress and transition into permanent housing and jobs. However, there are documented variances in the accessibility of such programs throughout the VA. Please describe how the VA monitors the quality and quantity of substance abuse/mental health treatment services offered throughout the system and what the Department is doing to improve programs in underserved areas.

Answer: The Mental Health Strategic Health Care Group carries out ongoing program evaluations of VA mental health and substance abuse programs through both NEPEC and the Program Evaluation and Resource Center (PERC). NEPEC includes some substance abuse workload data in its National Mental Health Program Performance Monitoring System Annual Reports and has annual reports on VHA's homeless veterans residential treatment and assistance programs. In general, the HCHV program employs case management for patients for a period of 3-6 months after which most veterans can participate in standard care. The VA Supported Housing (VASH) program is one part of VA's array of homeless care programs that does incorporate long-term intensive case management. VA is currently assessing the possibility of expansion of less intensive case management approaches in all its mental health programs by reviewing successful programs in the field. NEPEC's reports on homeless veterans care include outcome monitors such as number of veterans domiciled, number employed at discharge, and improvement in symptoms of mental disorders (which include substance abuse disorders).

PERC regularly conducts national surveys of every VA substance abuse treatment program to assess their structure, staffing, and services. PERC also calculates annually the number of substance abuse patients seen in every VA facility and network, the services they received, and conducts evaluations of the outcome of widely available modalities of VA substance abuse treatment. VA also mandates that all new substance abuse patients receive at intake and follow-up a structured assessment known as the Addiction Severity Index. National aggregation of the ASI data is conducted by the VA informatics center. The results are analyzed by PERC. This data shows how many veterans are benefiting from VA substance abuse treatment. Finally, in keeping with the requirements of capacity legislation, VA's Mental Health Strategic Health Care Group (MHSHG) coordinates annual reports on VA's capacity to treat patients who have substance use disorders.

Things VA Is Doing To Improve Programs:

- In general, VA's program development is based on Veterans Integrated Service Networks' (VISN)s' strategic plans. Further development of mental health capability for Community Based Outpatient Clinics (CBOCs) and enhancement of Mental

Health Intensive Care Management programs have been a feature of these plans over the past several years.

- The Veterans Millennium Health Care Act provided $15M for the expansion of Post Traumatic Stress Disorder (PTSD) and substance abuse treatment. Two-thirds of these funds were directed into the expansion of substance abuse treatment. The Program Evaluation and Resource Center intensively monitored all sites receiving these funds, working with MHSHG to resolve any implementation problems. As a result, the funds were expended as intended by the Congress, and the loss of substance abuse treatment capacity evident prior to 2000 began to stop. The PTSD programs established under the Millennium Act are similarly monitored by NEPEC and show consistent increased workloads.

- VHA has communicated a strong commitment to opiate substitution programs in written and oral form to the VA network directors. This may help explain why this type of substance abuse program is maintaining capacity better than others.

- VA's Research and Development Service has launched an initiative to improve practice through better use of scientific findings (The Quality Enhancement Research Initiative [QUERI] program). The mental health QUERI is focused on evidence-based practice in the treatment of depression and schizophrenia. The substance abuse QUERI includes a research grant awarded to the Minneapolis VA Medical Center to train VA clinicians nationwide to provide opiate substitution treatment more broadly, and at a higher level of quality. The effects of this initiative are reflected in the improvements of availability of Opiate Addiction Therapy in many networks.

- The VA has worked with the Department of Defense to develop clinical practice guidelines for Major Depression, Psychotic Disorders, and for substance abuse treatment, which emphasize evidence-based practice and teach clinicians how to provide it effectively. These guidelines have been widely distributed. The Psychoses Guideline is currently in revision and a PTSD guideline is under review.

5. Once your transition loan program awards loans, will the organizations receiving these loans continue to be eligible to participate in VA's grant and per diem program?

Answer: VA has approached the Loan Guarantee for Multifamily Transitional Housing for Veterans Program using a concept that would minimize the long-term financial obligation of this department. The purpose of the pilot program is to expand the supply of transitional housing for homeless veterans and provide a wide range of on-site supportive services. Simultaneous participation in VA's Grant and Per Diem Program would simply serve as the means for repaying a substantial portion of the VA guaranteed loan.

The commingling of these two programs would jeopardize the integrity of the Grant and Per Diem Program. The Grant and Per Diem Program is designed to be a program

based on fair and open competition that awards funding for homeless veterans program development to service providers that can demonstrate need in the community and ability to design a program to meet that need. Continued per diem payments are based on the organization's ability to provide effective services to homeless veterans. For programs that would receive both sources of VA financial support, any decision to withhold per diem payments because of poor services would have to be made within the context of a potential loan default. Grant and Per Diem Program selections could be compromised because of the distinct advantage that VA loan guarantee recipients have in showing pre-existing financial support. Finally, grant and per diem funds would be driven toward large urban areas since loan guarantee programs are targeted to those same areas.

6. The Veterans Comprehensive Homeless Assistance Act required HUD to set aside 500 rental assistance vouchers in FY 2003 and up to 2000 in FY 2006. However, no new vouchers have been designated for veterans. Please provide the Committee a status report on your actions to garner HUD commitments to provide these vouchers as required by law.

Answer: While Public Law 107-95 authorized the Department of Housing and Urban Development (HUD) to provide up to 500 Section 8 housing vouchers, specifically, for veterans in each year of four years, the provision has not been implemented, as Congress has not appropriated funds for the HUD VASH program. VA's Director of Homeless Programs has been in regular contact with various offices at HUD regarding this issue. VA has been and continues to be supportive of this joint initiative and urges implementation of this section. However, HUD, while supportive of the program, has advised VA that there is no provision in HUD's 2003 appropriation for implementation of these vouchers during the current fiscal year.

7. The Committee still awaits details from VA about plans for a national summit among HHS, HUD, and VA to establish better coordination between states and federal agencies to end chronic homelessness in the veteran population. What is the status of this national meeting, and when will it occur?

Answer: VA has been engaged with the Department of Health and Human Services (HHS) and HUD in an ongoing effort to bring state-level decision makers together at policy academy sessions to enhance the development of comprehensive state-level systems of care and services to end chronic homelessness.

The current plans include an opportunity for each of the states to attend a policy academy addressing the issue of chronic homelessness. On May 20-22, 2003, a policy academy session was held in Chicago, Illinois. Three additional state academies are scheduled, two of which will specifically address chronic homelessness.

A national academy with representatives from each state is tentatively planned for May 2004. We are very hopeful that this policy academy approach will be beneficial in aiding the effort to end chronic homelessness among veterans.

8. At our September hearing last year, the Department described a plan for VA, HHS and HUD staff to meet weekly to develop integrated initiatives on assistance for homeless veterans. As a result, VA stated it would commit up to $5 million, HHS would provide $10 million and HUD would provide $20 million. What is the status of this collaborative effort that seems promising, and your plans for activating the new facilities?

Answer: VA participated for more than six months in an effort to design an approach to offer funding to end chronic homelessness, including key components that would address the needs of veterans within that population. A joint NOFA was published and more than one hundred applications were received pursuant to the April 14, 2003, deadline.

The Interagency Council on the Homeless performed threshold reviews and each Department has performed a similar function. Each Department is conducting its evaluation of the appropriate component of each application. This summer a group comprised of HHS, HUD, and VA staff will review each application collaboratively for final ranking based upon a comprehensive review.

We are hopeful that decisions and a final announcement will be made by September 2003.

Of particular importance to VA is the concept that even if an applicant does not intend to primarily serve veterans, each applicant must present a plan that addresses the needs of veterans or the entire funding package will be denied.

9. Are there any existing conflicts in funding priorities because VA homeless programs are funded by health care funds from VA's Medical Care appropriation?

Answer: VA believes that its support of homeless programs has been robust, especially when one considers the $1.34 billion spent on all health care services for homeless veterans in FY 2002 (see also our response to question 10 below). Our FY 2004 budget indicates that total VA funding for specialized programs to assist homeless veterans will increase steadily from 2002 through 2004, as follows:

Obligations ($000)		
FY 2002	FY 2003	FY 2004
$137,187	$158,616	$174,001

10. In an exchange with Mr. Stearns during our hearing, you stated that VA puts only a miniscule fraction of its health care funding into homeless assistance programs - $25 *billion* or more is available for health care, but $25 *million* or slightly more is available for homeless programs. You acknowledged in that exchange that more funding is needed for those programs. Mr. Stearns requested an analysis describing this funding need. Please provide the Subcommittee with this analysis for Mr. Stearns.

Answer: It is important to note that VA spent nearly $1.34 billion on all health care services for homeless veterans in FY 2002. Within that amount, approximately $137 million was spent on specialized programs for homeless veterans, while another $1.2 billion was spent on treatment costs associated with homeless veterans' health care. Within funding made available for specialized programs for homeless veterans, $22.4 million was spent on the Homeless Providers Grant and Per Diem Program in FY 2002. In FY 2003, VA will spend approximately $50 million on the Grant and Per Diem program. In FY 2004, VA expects to spend approximately $69.4 million on the Grant and Per Diem Program. VA will continue to balance its priorities within the President's FY 2004 Budget request to implement the programs and services for homeless veterans authorized by Public Law 107-95.

11. Out of the recent sixty recommendations by the VA Homeless Advisory Committee, what recommendations will you implement? Please provide the Committee your rationale for not implementing the advisory committee's recommendations.

Answer: The Advisory Committee on Homeless Veterans Report identified thirty specific areas and 62 specific recommendations for VA to consider. The Department furnished the Committee on Veterans Affairs the first annual report as well as its replies to the Advisory Committee's recommendations on July 2, 2003. An additional copy of the report and VA's replies is enclosed with these questions.

○